

EMS Response to Domestic Violence

A Curriculum and Resource Manual

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EMS RESPONSE TO DOMESTIC VIOLENCE

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PREFACE

This resource manual is designed to be used in conjunction with an awareness program for emergency medical care providers. Domestic/family violence is an increasing public health concern and emergency health care providers are in a unique position to address this problem. Prehospital EMS personnel may be the first and only members of the health care system with which the victim of domestic violence comes in contact. While focusing on medical needs, you need to use your powers of observation to be able to “read between the lines” and be alert to the clues of domestic violence. Through this curriculum, you will develop the awareness necessary to recognize and confront this problem.

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GOALS AND OBJECTIVES FOR PRE-HOSPITAL DOMESTIC VIOLENCE CURRICULUM

GOAL

To equip and train EMS personnel with the necessary tools to properly identify, treat, and refer patients who are victims of domestic violence.

LEARNING OBJECTIVES

At the end of this presentation on EMS and Domestic Violence, the participant shall be able to:

1. Define “domestic violence.”
2. Describe the magnitude of domestic violence in Alaska, including its lethality.
3. List the three most common causes of domestic violence.
4. List three strategies to promote scene safety when responding to a domestic violence call.
5. List four questions, which can be asked by EMS providers at the scene to determine “victim” safety.
6. List four patterns of behavior in domestic violence.
7. List five signs that may assist field EMS personnel in recognizing domestic violence.
8. List three prevention strategies for domestic violence.
9. List the local resources for the emergency counseling and care of victims of domestic violence.
10. Describe the process of estimating the age of a bruise.
11. Describe at least two reasons why EMS personnel may be reluctant to ask the patient about the possibility of domestic violence.
12. Provide two reasons why EMS personnel can be effective agents for change in identifying and preventing domestic violence.

EMS RESPONSE TO DOMESTIC VIOLENCE

INTRODUCTION

EMS Response to Domestic Violence is provided as a guide to furnish EMTs with the information needed to understand the issues involved in responding to domestic violence. While pre-hospital providers are trained in patient assessment and the care of physical illness and injuries, scenes of domestic violence can include issues often outside an EMT's clinical training. Examples include scene safety, preservation of evidence at a crime scene, and resources or referrals for the victims of domestic violence.

DEFINITION

There are many terms used to define the violence that occurs between intimate adults. The most common include: family violence, battering, domestic assault, marital violence, spouse abuse, wife beating, and domestic violence. Whatever the term used, the key concept inherent to adult-to-adult violence is "control." Perpetrators of domestic violence have a specific goal: to establish and maintain power and control over another. During this course, we will be looking specifically at domestic violence between intimate partners. Domestic violence is defined as a pattern of assaultive and controlling behavior including physical, sexual, and psychological attacks, as well as economic control, which adults or adolescents use against their intimate partners.

Because domestic violence centers around intimacy, it is important to recognize that the violence that occurs between intimate adults is not exclusive to married partners but can also occur between boyfriend/girlfriend, ex-spouses, same-gender couples, and partners with an on-going or prior intimate relationship. According to the U.S. Department of Justice, Bureau of Justice Statistics, 90% - 95% of domestic violence victims are women. While we acknowledge that there are incidents of men being abused by women and some cases involve people of the same sex, throughout this text, we will refer to the perpetrator as "he" and the survivor or victim as "she".

Battered victims and batterers or perpetrators come from all economic and education levels, all racial and cultural groups, all religions, and all ages. Regardless of who the victim or batterer is, battering is a crime. No one has a right to hurt another. Battering may begin insidiously, with a push or shove, or perhaps a sharp criticism or an insulting remark. Once battering begins, however, it usually escalates -- both in frequency and severity. Domestic violence can include bodily injury, destruction of property, intimidation, coercion, revenge, and punishment. Threats of violence lay a foundation of fear -- all of which are methods to control the partner. When the batterer's threats put the survivor in fear for her safety or the safety of her family, children or property -- he has committed a crime.

It has been noted that the family is perhaps more violent than any other American institution or setting. It is important to understand that family violence -- child, spouse, and elder abuse -- is the only category of crime in which the perpetrator frequently voluntarily remains on the scene, expecting no negative consequences and actually perceiving intervention as a violation of his rights. Historically, domestic violence has focused on the victim and the result was a tendency to view domestic violence as a "women's issue." The focus of intervention was to determine why she was beaten or why she stayed. As such, the violence against the woman is viewed as her responsibility or fault -- the batterer is not held responsible for his behavior.

Despite a recent increased awareness of domestic violence, significant misunderstandings about its nature and extent exist especially within the medical field. Medical response to battered women has been traditionally to focus on the presenting medical problem, not the violence that causes the injury. The following pages are designed to increase awareness among emergency medical personnel that domestic violence is a preventable, public health problem, and provide tools for EMTs to better identify and care for victims of domestic violence.

SCOPE OF PROBLEM

Domestic violence is a significant public health problem. More than 5 million women are battered annually. According to the American Medical Association, nearly one-fourth of the women in the United States (more than 12 million) will be abused by a current or former partner sometime during their life. Over half the women murdered in the U.S. are killed by a current or former partner. The Federal Bureau of Investigation estimates that a woman is battered every 9 seconds in the United States. In 25% of homes where domestic violence occurs, the abuser will use violence against his female partner five or more times each year. Battering against women often increases during pregnancy, increasing the incidence of miscarriage, preterm labor and low birth weight. Battering is so common, that it is now the leading cause of injury to American women. If these statistics seem horrific, even more disturbing is the fact that a National Crime Survey showed that 48% of all incidents of domestic violence against women were never reported to the police.¹

In Alaska, according to the Council on Domestic Violence and Sexual Assault, domestic violence and sexual assault programs throughout the state served 13,057 clients in FY97. Further dividing by services sought:

➤ Crisis intervention	742
➤ Domestic violence	9,860
➤ Incest	536
➤ Sexual assault	1,862
➤ Unknown	57

¹ EMS Response to Domestic Violence A Curriculum and Resource Manual, New Mexico Department of Health

Domestic/Family Violence: Confronting the Monster, Shelda Shank, RN, BSN, PHN

Alaskan women face a much higher risk of homicide than women nationwide. Non-native Alaskan women are killed 1.5 times more often (6.2 per 100,000) than the national average (4.2 per 100,000) according to the University of Alaska Anchorage's Institute of Social and Economic Research. Native women are killed 4.5 times more often (19.1 per 100,000). In 1990, 50% of female murder victims in Alaska were killed by their husbands or boyfriends. In 1995, 80% of homicides in Alaska were related to domestic violence. In 1994, 4 of the 16 domestic violence related deaths in Alaska were children.²

The public health impact of domestic violence is compounded by the fact that the violence escalates in frequency and severity. Three-fourths of the women who are injured once continue to experience ongoing abuse. Without appropriate interventions, these women are at high risk of developing serious, complex medical and psychosocial problems, including suicide attempts.

A recent study found that 12% of female emergency department patients with a current male partner were recent victims of domestic violence. Battered women come in contact with other medical settings, including pre-hospital care providers, primary or ambulatory care centers, psychiatric services, and pre-natal care. The Pregnancy Risk Assessment Monitoring System (PRAMS) data for 1991 to 1994 revealed that 13% of women, who had recently given birth, had been physically hurt by someone close to them before or during pregnancy. Regardless of the health care setting, the traditional medical response to battered women has been to treat the presenting medical injury or illness without addressing the violence that may be at the root of the problem.

The cost of battering to the survivor, her children, the batterer, the health care system, criminal justice system, and society is staggering. Women who are abused have a much higher rate of alcohol and drug abuse, depression, suicide, anxiety, and miscarriage. The cost to children is both immediate and cumulative, from emotional disturbance during childhood to re-enacting the violence during adolescence and adulthood. Finally, the cost to the batterer is also significant, including employment problems, alcohol and drug abuse, homicide, arrests, fines and imprisonment. The cost to the community includes lost wages, sick leave, non-productivity, and absenteeism.

While financial costs may seem calculating, the emotional costs of domestic violence are immeasurable. Communities, like individuals, experience a collective loss of safety when domestic violence occurs and is not addressed. Individuals and communities experiencing and accepting domestic violence as a way of life become increasingly isolated.

DOMESTIC VIOLENCE: A PATTERN OF BEHAVIORS

Domestic violence is not an isolated, individual event, but rather a pattern of batterer behaviors used against a victim. The pattern is typically a variety of abusive acts, occurring more than once over the course of the relationship. The battering episodes can

² Council on Domestic Violence and Sexual Assault, 1996-1997 Bi-annual Report

take many forms and last a few minutes to several hours or days. Some batterers will repeat a particular set of abusive acts, while others will use a wide variety with no pattern.

Each episode is connected to the others. One battering episode builds on past episodes and sets the stage for future episodes. Some behaviors are crimes in most states (e.g., physical assaults, sexual assault, menacing, arson, kidnapping, harassment) while other behaviors are not illegal (e.g., name calling, interrogating children, denying the victim access to the family car). All parts of the pattern interact with each other and can have profound physical and emotional effects on victims.

The battering behaviors take different forms: physical, sexual, psychological, and economic. In the first two behaviors, the batterer has direct contact with victim's body. The other categories involve tactics where the batterer has no direct contact with the victim's body although the victim is clearly the target of the abuse.

Physical Assaults

Physical abuse may include spitting, scratching, biting, grabbing, shaking, shoving, pushing, restraining, throwing, twisting, slapping (with open or closed hand), punching, choking, burning, and/or use of weapons (e.g., household objects, knives, guns) against the victim. These assaults may or may not cause injury. Sometimes a seemingly less serious type of physical abuse, such as a shove or push, can result in the most serious injury. The batterer may push the victim against a wall, down a flight of stairs, or out of a moving car, all of which could result in varying degrees of trauma.

Sexual Assaults

Some batterers sexually batter their victims. Sexual assault consists of a wide range of conduct that may include pressured sex when the victim does not want sex, coerced sex by manipulation or threat, physically forced sex, or sexual assault accompanied by violence. Victims may be coerced or forced to perform a kind of sex they do not want (e.g., sex with third parties, physically painful sex, sexual activity they find offensive, verbal degradation during sex, viewing sexually violent material) or at a time when they do not want it (e.g., when exhausted, when ill, in front of children, after a physical attack, when asleep). Some batterers attack their victim's genitals with blows or weapons. Some deny victims contraception or protection against sexually transmitted diseases. The message to the victims is that they have no say over their own bodies. Some victims will find this difficult to discuss and other victims are unsure whether this sexual behavior is really abuse, while other victims see it as the ultimate betrayal.

Psychological Assaults

There are different types of psychological assaults.

Threats of violence and harm

The batterer's threats of violence or harm may be directed against the victim or others important to the victim or they may be suicide threats. Sometimes the batterer will threaten to kill the victim and/or others, as well as threaten to commit suicide. The threats may be made directly with words or with actions (e.g., stalking, displaying weapons, hostage taking, suicide attempts). Some batterers will use violence towards others as a means of terrorizing the victim. Others may force the victim into doing something illegal (e.g., prostitution, burglary) and then threaten to expose them, or may make false accusations against them (e.g., reports to DFYS, to the welfare department, or to immigration).

Attacks against property or pets and other acts of intimidation

Attacks against property and pets are not random acts, (e.g. the wall the victim is standing near that gets hit, the door she is hiding behind gets torn off of its hinges, the victim's favorite china gets smashed or her pet cat is strangled in front of her and he says, "Look what you made me do."). But, the message is always, "You could be next."

The intimidation also can be carried out without damage to property, by the batterer yelling and screaming in the victim's face, standing over the victim during a fight, driving recklessly when the victim or children are present, stalking, or putting the victim under surveillance. The intimidation may not always be a threat of physical harm, but may be carried out by damaging the victim's relationships with others or her reputation in her community by discrediting her with employers, ministers, friends, and neighbors.

Emotional abuse

Emotional abuse is a means of control that consists of a wide variety of verbal attacks and humiliations. It can include repeated verbal attacks against the victim's worth as an individual or role as a parent, family member, friend, co-worker, or community member. The verbal attacks often emphasize the victim's vulnerabilities (such as her past history as an incest victim, language abilities, skills as a parent, religious beliefs, sexual orientation, or HIV status).

Sometimes the batterer will play "mind games" to undercut the victim's sense of reality (e.g., specifically directing her to do something, then claiming that he never asked her to do it when she complies). The batterer may force the victim to do degrading things (e.g., getting on her knees and using a toothbrush to clean up food that the batterer smeared on the kitchen floor, or going against her own moral

standards). Emotional abuse may also include humiliating the victim in front of family, friends or strangers. Batterers may repeatedly claim that victims are crazy, incompetent, and unable “to do anything right.” These tactics are used to maintain power and control over the victim and are similar to those used against prisoners of war or hostages.

Not all verbal insults between partners are acts of violence. To be considered domestic violence, it must be part of a pattern of behaviors in which the batterer uses or threatens to use physical force. In domestic violence, verbal attacks and other tactics of control are intermingled with the threat of harm in order to maintain the control and dominance through fear. While repeated verbal abuse is damaging to partners and relationships over time, it alone does not establish the same climate of fear as verbal abuse combined with the use or threat of physical harm.

The presence of emotionally abusive acts may indicate hidden use of physical force or it may indicate possible future domestic violence. Research at this point can not predict which emotionally abusive relationships will become violent and which will never progress beyond verbal abuse. If the victim feels abused or controlled or afraid of her partner without showing or offering clear indications of physical harm, then the cautious approach would be to accept the patient’s views as stated and to respond with concerns about the victim’s safety and psychological well-being.

Isolation

Batterers often try to control the victim’s time, activities and contact with others. They gain control over them through a combination of isolating and disinformation tactics. Isolating tactics may become more overtly abusive over time. The batterer may start by cutting off victims from supportive relationships with claims of loving them “so much” and wanting to be with them all the time. In response, the victims may initially spend increasing amounts of time with their batterer. These subtle means of isolating the victim are replaced with more overt verbal abuse (e.g., “interfering” family, complaints about her spending too much time with others); sometimes the batterer uses physical assaults or threats of assault to separate the victim from her family or friends. He may lock her out of her house or control her movements by taking her car keys or forcing her to quit her job. The batterer will often move the family to a new location, away from the victim’s family, friends, and her support system in general.

Batterers’ use of disinformation, distorting what is real through lying, providing contradictory information, or withholding information is compounded by the forced isolation of the victims. While many victims are able to maintain their independent thoughts and actions, others believe what the batterers say because the victims are isolated from confirming or denying the information.

The batterer can also isolate the victim by acting jealous and interrupting social/support networks. They often accuse the victim of sexual infidelity and of

other supposed infidelities, such as spending too much time with children, the extended family, at work, or with friends. They claim that family or friends are trying to ruin their relationship. This jealousy about alleged lovers, friends, or family is a tactic of control.

Use of Children

Some abusive acts are directed against or involve the children in order to control or punish the adult victim (e.g., physical attacks against a child, sexual abuse of the children, forcing children to watch the abuse of the victim, engaging children in the abuse of the victim). A batterer may use children to maintain control over his partner by not paying child support, requiring the children to spy, threatening to take the children away from her, involving her in long legal fights over custody, or kidnapping or taking the children hostage as a way to force the victim's compliance.

Children also can be drawn into the assaults and are sometimes injured simply because they are present. The batterer can also use visitation with the children as an opportunity to monitor or control the victim. These visitations become nightmares for the children as they are interrogated about the victim's daily life.

Use of Economics

Batterers often control victims by controlling their access to all of the family resources, including: time, transportation, food, clothing, shelter, insurance, and money. It does not matter who the primary provider is or if both partners contribute. The batterer is the one who controls how the finances are spent. They reduce the victim to having to get "permission" to spend money on basic family needs.

When the victim leaves the battering relationship, the batterer may use economics as a way to maintain control or force her to return. He may do this by refusing to pay bills, instituting legal procedures costly to the victim, destroying assets in which she has a share, or refusing to work "on the books" where there would be legal access to his income. All of these tactics may be used regardless of the economic class of the family.

The Research on "Mutual Battering"

Some argue that there is "mutual battering" where both individuals use physical force against each other. In such cases careful assessment often reveals that one partner is the principal physical aggressor while the other attempts to defend herself or protect her children (e.g., she stabbed him as he was choking her). Research on heterosexual couples indicates that women's motivation for using physical force is often self-defense while men often use force for power and control. Self-defense against an abusive partner does not mean "mutual battering" is occurring. Victims are engaging in survival strategies during which they sometimes resist the demands and forced

control of the batterer. Batterers respond to such resistance with escalating tactics of control and violence.

Changes in the Batterer's Abusive Pattern

A batterer's pattern of abusive behavior may change. Sometimes the batterer uses more psychological tactics and at other times more physical abuse. There is no evidence that domestic violence progresses in a straight fashion from verbal insults to minor assaults to homicide. Some batterers' physical violence escalate, while for others the use of physical violence stabilizes or even decreases as their use of other tactics increases. The batterer will change behavior and use tactics that are most useful in gaining and maintaining control. There is no evidence that a batterer will stop on his own. Even in research, where the use of physical force seems to have stopped for a period of time, it is unclear whether the batterer merely switched to non-physical tactics of control or whether the end of physical force will be permanent.

DOMESTIC VIOLENCE: PURPOSEFUL, COERCIVE BEHAVIOR

Domestic violence is purposeful and directed at achieving compliance from or control over the victim. The pattern is not random or "out of control" behavior. Batterers who minimize or excuse their behavior by claiming they "lost it" or "were out of control" have actually made specific choices. Batterers follow their own internal set of rules for their behavior. Some will batter only in particular ways (e.g., hit certain parts of the body). Others use violence only toward their victims even though they may be angry with their boss, other family members or friends. Some will only hit in private, while others hit in public. Such decision-making indicates that they are actually in control of their abusive behaviors.

Interviews with batterers reveal that when using both obvious and not so obvious forms of abuse, batterers know what they want from victims. Batterers will use varying combinations of physical force and/or threats of harm and intimidating acts to instill fear in victims. At times they will use other kinds of manipulations through gifts, promises and indulgences. Regardless, their intent is to get something from the victim, to establish domination over them, or to punish them. Batterers selectively choose tactics that work to control their victim.

UNDERSTANDING THE CAUSES OF DOMESTIC VIOLENCE

This section is provided to increase your knowledge of the dynamics of violent relationships and the characteristics of survivors and batterers. A comprehensive understanding of the cultural, familial, psychological and personal factors that create and perpetuate domestic violence will enable the EMS provider to recognize and more effectively manage domestic violence calls.

Learned Behavior

While male and female sex roles lay the foundation for dominance/submission, they do not explain violence. Witnessing violence in the home is the most powerful model for the transmission of violence from one generation to another. Researchers report that boys who either watch adult-to-adult domestic violence or are battered themselves are, as adults, more likely to batter their female partners. Youth who live in violent families learn to accept some domestic violence as a legitimate means of discipline. It is also learned through the reinforcement of the batterers' experiences (e.g., batterers receiving peer support or not being held responsible, arrested, prosecuted, or sentenced appropriately for their violence).

Domestic violence is repeated because it works and thus the pattern of behavior is reinforced. The use of abusive conduct allows the batterer to gain control of the victim through fear and violence. Gaining the victim's compliance, even temporarily, provides partial reinforcement for the batterer's use of abusive tactics. Often the battering behavior is reinforced by the responses of peers, family authorities, and bystanders. But most importantly, the batterer is able to reinforce his own abusive behavior. He is able to justify his actions to himself because of the commonly held belief that men have the right to control women in relationships and have the right to use force to ensure that control.

Domestic Violence and Gender Roles

Societies tend to assign males and females different expectations for personality traits, expressions of emotion, behaviors and occupations. In the United States, this differentiation has historically ranked the sexes in such a way that women are generally unequal in power, resources, and prestige or presumed worth. Men are socialized to take control and to use physical force when necessary to maintain dominance. While most victims of male violence are other men, the majority of victims of domestic violence are female, although female-to-male, male-to-male (gay), and female-to-female (lesbian) violence also occurs in some intimate relationships. In heterosexual relationships, some women sometimes use physical force, but their use of physical force is not always at the same rate or severity as men's. Studies also indicate that the use of physical force by women is primarily for self-defense, whereas men often use force for power and control. It has been shown that some battered women who kill have used force to protect themselves from the severe violence of male batterers.

Domestic Violence is Not Caused by Alcohol or other Drugs

Drug and/or alcohol abuse does not cause domestic violence. Many people use or abuse drugs without ever battering their partners. Stopping drug abuse will not stop domestic violence and we would be mistaken to think that we can treat the addiction problem and the domestic violence would stop. Alcohol is a disinhibitor, but cannot be blamed for violence. Many abused women learn to use drugs or alcohol to numb themselves from the emotional and physical pain they are experiencing.

While research studies have found high relationships between aggression and the consumption of various substances, there is no data clearly proving a cause-and-effect relationship. Some say that alcohol and drugs provide a disinhibiting effect which gives the individual the inclination to do things that they otherwise would not do. Others look at the increased irritability or hostility which some individuals experience when using alcohol or other drugs and which may lead to violence.

A big concern when alcohol or other drugs are involved is the assessment of lethality. Their presence may increase the potential lethality of domestic violence and must be carefully considered when addressing the safety of the victim, the children, and the community.

Domestic Violence is Not Caused by Anger

The role of anger in domestic violence is complex and cannot be reduced to a simple cause-and-effect. Some battering episodes occur when the batterer is not angry or emotionally charged, and others occur when the batterer is emotionally charged or angry. Some displays of anger or rage by the batterer are merely tactics used to intimidate the victim, and can be quickly altered when the abuser thinks it is necessary (e.g., upon arrival of police).

Keeping in mind that domestic violence is a pattern of behaviors rather than isolated, individual events help to explain the number of abusive episodes that occur when the batterer is not angry. Even when angry, the batterer still chooses to respond to that anger by acting abusively. Ultimately, the individual is responsible for how he expresses anger or any other emotion.

Domestic Violence is Not Caused by Stress

Life is filled with many different sources of stress and people respond in a wide variety of ways. People choose ways to reduce stress according to what they have learned about strategies that have worked for them in the past. It is important to hold individuals responsible for the choices they make regarding how they reduce stress, especially when those choices involve violence or other illegal behaviors. Many episodes of domestic violence occur when the batterer is not emotionally charged or stressed. Since domestic violence is a variety of tactics repeated over time for the purpose of controlling the victim, specific stresses are less meaningful in explaining a pattern of abusive control.

Domestic Violence is Not Caused by the Victim's Behavior or by the Relationship

Focusing on the relationship or the victim's behavior as an explanation for domestic violence removes the batterer's responsibility for the violence and supports the batterers' minimization, denial, blaming, and rationalization for the violent behavior. Other person's relationships can be in conflict and experience negative feelings about the behavior of their partner without choosing to respond with violence.

Research indicates that there are no personality profiles for battered women and they are no different from non-battered women in terms of psychological characteristics. One study found that no victim behavior could alter the batterer's behavior, suggesting that the victim's behavior is not the determining factor in whether or not the batterer is abusive.

Both adult and adolescent batterers bring into their intimate relationships certain expectations of who is to be in charge and what mechanisms are acceptable for enforcing that dominance. Those attitudes and beliefs, rather than the victim's behavior, determine whether or not they are violent.

PHASES OF VIOLENCE

Although it is not the same in all relationships, the pattern of domestic violence usually consists of three phases: increased tension building, the acute battering incident, and a calm or a lessening of tension.

Phase 1: Tension or Build Up

The tension-building phase may last weeks, months or years. With time, this phase becomes shorter and shorter, in some cases it could be as short as a few minutes or hours. An increase in verbal or physical abuse and a decrease in loving communication characterize it. This is a time when the victim may be amenable to resources in the community and may even seek them by a visit to a member of the clergy, a physician or another authority figure she trusts. She tries to keep the man as calm as possible, fearing that any escalation in tension will also increase his dangerousness. Sometimes a battered woman who has been through the cycle before knows that an acute battering incident is about to occur. She may do things she believes he will explode over, sometimes in front of other people. Her goal is to get the abuse over with while his violence level is still relatively low. The batterer may also feel increased tension, but will deny this to himself. The batterer is unwilling to seek or listen to help at this point.

Phase 2: Battering Incident

In the second phase, the tension has reached a certain point and an explosion or fight will occur. This is usually when the physical violence occurs. He knows, or will learn, that his use of violence seems to decrease his stress and change his partner's behavior. Either partner may initiate the acute battering phase. It is during this phase that law enforcement or EMS become involved. If there are serious injuries requiring medical care, they usually occur during this phase. Immediately following this phase, the batterer and the survivor may be amenable to intervention. She is hurt and frightened, and he often feels guilty, humiliated and ashamed.

Phase 3: Calm or Honeymoon

In the calm or "honeymoon" phase there is a perception of reconciliation and resolution. The man is usually contrite, offers excuses such as drinking, and promises that it will never happen again. This phase tends to be shorter than the tension phase. The

honeymoon phase does not exist in all relationships, and in other relationships, decreases and disappears over time as the man's power and control needs are achieved by increasing frequency and severity of the violence. The survivor is least likely to be amenable to intervention at this time, because it is the period when she receives the most rewards for being in the relationship. She is reminded of the earliest period of courtship, when the batterer behaved in a loving and nurturing manner with no observable violence. In contrast, the batterer may be more amenable to intervention at this time, because typically he is remorseful and wishes to keep his partner. Later in the phase, as soon as he believes he has again won over his partner, he is decreasingly amenable to intervention. During the height of this phase, both parties minimize the violence and may excuse, distort, or actually forget what happened.

ROLE OF EMS PROVIDERS

Many EMTs and paramedics are drawn to emergency medical services because of the opportunity to make a dramatic contribution to persons in need. With adrenaline pumping, we respond to the scene and get great satisfaction when the person in critical need receives medical care and improves during transport to the hospital. We become partners with emergency physicians and nurses in a daily struggle to save critically ill or injured patients.

But beyond the excitement of the moment is a more sobering reality. As health care providers involved in our community, we must look beyond the occasional dramatic rescue. EMS professionals are often the first or only medical contact with an injured victim of domestic violence. In some rural communities, we may be the most sophisticated medical people available to identify or refer a victim of domestic violence.

Emergency pre-hospital care providers may have a unique opportunities for intervention of domestic violence, specifically in the identification of abuse and referral to appropriate resources. Unfortunately, the majority of battered women who are treated by EMS providers are not identified as victims of domestic violence and thus, are offered no assistance or information to deal with a potentially life-threatening problem. In addition, EMS may be the only witness to the home environment. EMS identification of domestic violence can be the first step in interrupting the progression of violence and prevent the development of a variety of other complex problems. To do this, EMS providers need an understanding of the definition, extent, and nature of domestic violence.

Historically, health care providers have dealt with domestic violence by ignoring it. Health care providers may feel intimidated by the batterer and are reluctant to get involved. In a small community, we may know both the victim and perpetrator and feel intrusive if we say anything. We may feel this is a family issue, not a medical one. We may also feel frustration or disgust when we see the victim return to the batterer time and again. We may feel that there is little or no community support and that the health care system is ineffective if the legal system doesn't back its efforts.

Efforts to address domestic violence will require multi-disciplinary collaboration. Initial steps can be very simple. Individuals can examine their own behavior and educate themselves and their friends on violence-related issues. Careful consideration can be given to the content and messages of movies and television. We can encourage youth to avoid violence as a response and teach young girls that violence against them is unacceptable. We can support shelters that help battered women and refer suspected victims of domestic violence to these support services. We can begin the empowerment of the victim by concluding that, “Domestic violence is such a serious health problem that I ask all my patients: Has someone you know caused these injuries?”

Despite the criminal nature of domestic violence and unlike abuse inflicted upon children, battered women are independent and fully capable of making decisions that best meet their needs. The goal for intervention is to empower women with information, resources, and support. The decision to call police or pursue legal action is a decision that rests with the battered woman alone. You may not be able to stop the violence within a relationship, but you can offer help. By heightening your own awareness and offering support services that may be available to the victim, you can acknowledge that she is not alone, that she does not deserve the violence, and that there are resources to help her when she decides to leave the batterer.

Do not judge the success of your intervention by the patient’s action. It may be frustrating to you when a patient stays in an abusive situation but that is her decision. Be assured: if you have acknowledged and validated her situation and offered her the appropriate referrals, you have done what you can to help.

RESPONDING TO A DOMESTIC VIOLENCE SCENE

Calls to domestic violence are considered among the most potentially dangerous of scenes. Law enforcement agencies dispatch multiple officers to answer domestic disturbances as a strategy to reduce the potential of danger. Law enforcement’s approach to domestic disturbances require heightened awareness to all possible clues, ranging from the initial assessment of bumper stickers on vehicles (for example, “This vehicle protected by Smith and Wesson”) to tricycles in the driveway (presence of children) to recommendations to avoid bedrooms (most typical room for accessible firearm) and kitchen (room where most anything can be used as a weapon).

Similar warnings are relevant for EMS personnel. For example, the initial call may just not sound right -- whether an “unknown” or 911 hang-up -- or the calling party denies calling EMS when you arrive at the door. These are clues and should be used as signals to heighten your awareness in responding to the scene. As you approach, look around the yard. Notice, which lights are on in the house. Wait and listen as you approach: do you hear yelling or sounds of a struggle?

If law enforcement has not been called, call them now. **DO NOT ENTER UNTIL POLICE ARRIVE AND SECURE THE SCENE.** The personal safety of the EMS provider outweighs the need to respond -- this might be the toughest judgment call you'll ever have to make. Your adrenaline is pumping, you are ready to respond, to stop the bleeding or save a life but remember: If you're hurt, you are not helping anybody, and you are adding to the burden of others who now need to respond to you as well as to the original patient.

For these reasons and more, exercise caution and heightened awareness when responding to a scene of potential domestic violence. Ask yourself the following when responding to potentially high risk calls:

- ⇒ Should I approach?
- ⇒ Are there obvious dangers in approaching?
- ⇒ Who is the subject I will be dealing with? Is there prior history in responding?
- ⇒ Who am I? What are my limitations, my strengths, my own history?
- ⇒ What help is available?
- ⇒ When is the contact taking place (at night, during the day, in a trailer, etc)?

Once inside, your awareness needs to continue. While the police may have already secured the scene, it is appropriate for you to do the same. Visually frisk everyone for weapons. Determine who is in the residence and where they are. Once identified, spectators should be asked to leave. Don't allow residents to get between you and an exit route. Don't let yourself be backed into a corner. Know where your partner is at all times. Don't get tunnel vision when treating a patient; ensure that your partner is equally aware of what else is going on. Observe the body cues of others in the room, such as clenched fists, flared nostrils, and flushed cheeks. If the scene is otherwise safe but weapons, or potential weapons, are present in the room, you should ask that they be put away. It may help to practice a standard response to this type of situation, so that you will be prepared at the scene. One sample response is "For your safety and mine, I need to ask you to put the weapon away." You should make a mental note of the type and location of the weapon in case you are asked about it by law enforcement personnel.

EMS personnel need to recognize and be aware that while they were originally called to help. Their presence, along with law enforcement, changes the dynamics of the scene. Specifically, either the victim or perpetrator may turn on you or the police at any time. For example, before EMS or law enforcement arrives the confrontation is between the batterer and the victim. The confrontation is the perpetrator's attempt to obtain or maintain control over the victim. Once outside help arrives, the two-way tension changes and now involves three or more people.

Once the aggressor or violent husband is arrested, his role is changed and he perceives himself as the victim. By the arrest procedure itself, the police officer now becomes a potential threat to the perpetrator. This change effects the role of the victim, who may decide to side with her husband against the police officer. Why? Victims may go after the police because if they don't do everything possible to help release their perpetrator they'll get beat again as soon as he is released. (She isn't trying to "rescue" her husband, but is

trying to stay alive.) This is a primary reason why law enforcement officers are apprehensive to respond and intervene in these types of calls: they are often injured at the scenes of domestic violence calls. Nationally, of all officers who are assaulted in the line of duty, one third occur at domestic violence scenes, and domestic violence calls account for an increase in the number of law enforcement deaths, from 3.1% of all deaths in 1986 to a total of 7.1% of police officer deaths occurring in domestic violence calls in 1995.

While EMS may have been called to provide medical care, it is important to recognize the change in dynamics and that the delivery of medical care may be viewed as a threat. The presence of a rescuer -- whether law enforcement making an arrest or EMS providing medical care -- changes the dynamics between the perpetrator and victim. It also must be remembered that women are in the most danger when they try to leave their abuser. Studies show that 75 percent of battered women are beaten **after** they leave (e.g. at the time of the beating incident, they were either divorced or separated).

Part of the problem in responding to a domestic violence scene is that in all probability, the violence has been occurring for some time. The violence may have escalated over the years, to the point where the victim may be unaware of how lethal it has become. Victims and perpetrators consistently minimize the level of violence experienced. Also, many victims are embarrassed, shocked, or feel responsible and want to minimize the violence out of guilt and shame. The victim may be fearful: a past arrest may not have been effective and violence was inadvertently encouraged.

In addition to the dynamics of the scene, it may be necessary to diffuse aggressive behavior before you can even approach the victim to deliver medical care. Avoid touching or crowding an already hostile person since it may provoke more violent behavior. Be non-threatening. Stay calm. Don't get too close. Take a balanced stance. Take your time and take nothing for granted. Assume control of the situation SLOWLY. Introduce yourself, speaking directly to the patient. Explain what you're doing. Ask open-ended questions, allowing them to talk. Restore control to the victim. Do not be judgmental. If you can, separate yourself and the victim from the perpetrator -- an explanation may be that you need to use equipment that is in your ambulance.

Pay attention for early warning signs of a potential attack. Sample behavior and physical posturing include:

- ⇒ conspicuous ignoring of questions and statements by you or police;
- ⇒ repetitious questioning;
- ⇒ looking around nervously;
- ⇒ excessive emotional attention;
- ⇒ ceasing all movement;
- ⇒ physical crowding;
- ⇒ assuming a pre-attack posture;
- ⇒ target glance.

These are clues for EMS personnel to heighten awareness and to ensure your own personal safety.

RECOGNIZING AND TREATING VICTIMS OF DOMESTIC VIOLENCE

The odds are very high that most of us, as emergency care providers, have treated victims of domestic violence during our career. Maybe we had no awareness of what we were responding to. Or just maybe, we had a very real suspicion of domestic violence but didn't know how to deal with the situation. Should we have expressed our concern? What do we say or do? What if the patient denies being abused, what then?

While victims of domestic violence may not offer details on their own initiative, they may discuss it if asked simple, direct questions in a non-judgmental way and in a confidential setting. The patient should be interviewed alone. This cannot be emphasized enough: Question the victim directly about battering only if the suspected abuser is not present. Your ambulance may provide a safe environment for the victim of domestic violence to admit to a problem and ask for assistance. Your ambulance may provide the ideal opportunity for an EMS responder to question the patient and uncover any abuse that is occurring. Ask the patient direct, non-threatening questions in an empathetic manner, emphasizing that certain questions are asked of all trauma patients.

You may want to think of sample questions ahead of time so that you will be comfortable and ready when the situation arises. Listed below are some sample direct and non-judgmental approaches. Consider practicing or modifying these statements to see which ones feel appropriate for you:

- ⇒ Because domestic violence is so common in today's world, I've begun to ask about it routinely. Has your partner done this to you?
- ⇒ We often see people with injuries such as yours which are caused by someone they know. Could this be happening to you?
- ⇒ You seem frightened and anxious. Has someone hurt you?
- ⇒ Sometimes when others are over-protective and jealous, they react strongly and use physical force. Has this been happened to you?
- ⇒ Are you afraid of anyone in your household?
- ⇒ Has any household member physically hurt you or threatened to hurt you?

At first, you may find it difficult to ask these questions. You may think them to be intrusive or that you are being nosy. However, these kinds of questions should be part of your patient assessment. It may help to explain that questions of this sort are asked of all injured patients and that these questions are part of your protocols. Practice, and learn which ones work best for you.

The series of questions to ask can be easily remembered with the "SAFE" acronym.

- S** Do you feel **SAFE** in your relationship?
Should I be concerned for your **SAFETY**?

- Are there situations in your relationship where you have felt
- A AFRAID?**
What happens when you and your partner disagree or **ARGUE**?
- Are your **FRIENDS** aware that you have been hurt?
- F** Do your **FAMILY** members know about the abuse?
Would **FAMILY** or **FRIENDS** be able to help or support you?
- Do you have a safe place to go in an **EMERGENCY**?
- E** If you needed to leave now, do you have an **ESCAPE** plan?
Would you like to talk with an advocate to develop an **EMERGENCY** safety plan?

ASSESSMENT OF INJURIES

Accurate and thorough assessment is the first step in establishing a trusting relationship with the victim of domestic violence. The assessment process is the first step in documentation of the injuries. Your assessment also allows you to provide information on resources and services available while you determine how lethal the situation is through sensitive questioning.

A survivor of domestic violence must be assessed in private, away from the partner. Assessment of injuries in front of the partner endangers the victim. Battering is a crime of silence and the EMS assessment of the injuries threatens the silence. It may help to maintain eye contact with the victim; however, this may be inappropriate for some individuals or cultures. Trust is a necessary component of the assessment: do not badger or push the victim into disclosing what she may not be ready to share. In an environment of privacy and safety, allow the patient to describe her situation.

At the same time you are establishing trust, you are responding to the patient's injuries. Injuries that should raise suspicion of domestic violence include those that follow a certain pattern to the face, chest, or abdomen. Perpetrators often, quite knowingly, strike areas of the body that are covered by clothing. Other suspect injuries include bruises or fractures to the forearm, suggesting a defensive posture. Be suspicious of isolated bruises to the abdomen or a "blowout" fracture of the face, especially if attributed to running into household furniture. A blowout fracture, which involves a fracture of the fragile bone under the eye, typically indicates a direct blow to the face.

Documented studies of domestic violence generally report the following physical sites and percentages of injuries:

- 33% Face and neck
- 16% Arms
- 14.5% Head
- 12% Back and buttocks

- 10% Breasts
- 5.5% Abdomen (Increases during pregnancy)
- 4% Genital

Another important aspect of injuries from domestic violence refers to victims who are repeatedly abused. Keeping this in mind, you may encounter injuries in different stages of healing. It may help to review how to estimate the age of a bruise:

COLOR	AGE
Red to Reddish Blue	Less than 24 hours
Dark Purple/Dark Blue	1 to 4 days
Greenish/Yellow Green	5 to 7 days
Normal tint/Disappearing	1 to 3 weeks

DOCUMENTATION

Throughout the delivery of medical care, EMS personnel need to be sensitive to preserving or documenting evidence that may be used in bringing charges against a perpetrator. Successful prosecution of the case depends to a great extent on the quantity and quality of evidence gathered at the crime scene. Well-documented cases are more likely to be pursued by public prosecutors and are more likely to result in appropriate legal actions against the offender.

Besides the obvious evidence of medical and police reports, documentation includes descriptions of damage to the house and statements from witnesses who heard or saw the abuse. If law enforcement has been called to the scene, the information in the EMS medical form supports the police documentation. If, however, EMS is called to a scene without police being present -- for example, if the victim is denying or minimizing the injuries as a result of domestic violence -- then the documentation collected by EMS is especially critical in supporting a future charge.

The documentation you put in your report may be the most important piece of information when it comes time to support charges of domestic violence. Your report could be used in criminal prosecution, and you could be subpoenaed as a witness. Make sure you document details when responding to a known or suspected domestic violence call.

Specifically, document inconsistencies between the victim's injuries and the history or description of mechanism of injury. Provide descriptive detail of injuries. If, for example, a bruise to the face has the imprint of a hand and fingers, make note of this. Also of note are the conditions of the residence, including broken furniture, holes in walls or doors, disarray, or broken glass. Make note of comments from the suspected perpetrator or the demeanor of

children if they were present. Identify weapons if present or used. Record alibi statements and even spontaneous outbursts. Use quotes when possible. If the victim is transported to the hospital, you, as the responding EMT, may be the only one who can document the details of the scene. Lastly, remember, if it is not documented, it is hard to substantiate that it happened.

THE AFTERMATH

After assessing a victim of domestic violence, treating her injuries, and documenting the situation, plans for her safety should be discussed. First ask her if she feels safe and help her look at available options:

- ⇒ Does she have friends and family with whom she can stay?
- ⇒ Does she want access to a shelter or would she prefer information for when she's ready?
- ⇒ Does she want access to counseling?
- ⇒ Does she want to return to her male partner?
- ⇒ Does she want referrals to police or legal services?
- ⇒ Does she have an extra set of clothes, important papers, and other essentials stored somewhere safe for when she needs to leave?

Use empathetic and active listening skills when discussing options with the victim of domestic violence. The woman must have control of the conversation for the healing process to begin. A battered woman can and will evaluate her own situation. She may need help in identifying resources, but she also must make her own decision. If she's not ready, remember it is her choice. Battered women may leave their abusive situation anywhere from five to seven times before they are able to safely separate from their perpetrator. As a process, these "leaves" give her the time to develop resources, test support systems, and gather strength. The pre-hospital health care provider can help the victim through this process by validating her decision-making skills and informing her of her options.

Nine times out of ten, when police officers respond to a domestic violence call, the perpetrator has already left the scene. When the perpetrator leaves the scene, it can create a potentially dangerous situation for the victim who may refuse to leave the residence. The perpetrator may then come back at a later time and possibly inflict more harm on the victim or any children or other people present. It is highly recommended for the victim to leave the residence for the night.

Victims and their children can be offered refuge at a local domestic violence shelter. First contact the shelter and advise them of the situation. Typically, they will meet you at the police department where they will pick up and transport the victim and her children. Victims also can be transported to the residence of a relative or friend if they do not wish to stay at their residence. Police officers can "stand by" at the residence while the victim retrieves any immediate personal effects that are needed for her or the children.

Alaska statutes provide for probable cause arrest in cases of domestic violence. An officer with or without a warrant may arrest someone if there is probable cause to believe that a crime occurred (e.g. an act of domestic violence, a violation of a protective order, or a violation of conditions of release) in or out of the officer's presence. If the incident occurred within 12 hours of the officer's investigation, the officer is mandated to make an arrest. Officers are required to identify the principal physical aggressor in incidents where both parties are claiming to be the victim and to only arrest the principal physical aggressor.

It is critical to stress to the victims to document reports and the possible results of their actions. Explain that you understand the dynamics of domestic violence. Also, explain that if some type of intervention does not occur, the frequency and the severity of the attacks may increase. Assure the victim that she is not alone, that violence is not normal behavior, and that resources are available to her when she is ready to access them. And finally, if children are involved, emphasize the potential dangers to them.

DOMESTIC VIOLENCE AFFECTS CHILDREN

The potential danger to children in households where domestic violence occurs is two-fold. The first is the immediate: children may become victims of the abuse. The second, or long-term effect, is much harder to measure: children learn their parents' behaviors.

In the immediate sense, children in homes where domestic violence occurs are often physically abused or seriously neglected. A large study of more than 900 children at battered women's shelters found that nearly 70% were themselves victims of physical abuse or neglect. A child may receive physical injuries directly, as a result of the violence, or indirectly. Children can be hurt when household items are thrown or weapons are used. Infants may be injured if being held by their mother when the batterer attacks. Older children may be hurt while trying to protect the mother. As a result of the myriad problems within a violent household, child neglect can occur and can result in both physical and emotional injuries.

In the immediate situation, EMTs can have a positive impact on children. Whether responding to a child's physical injuries or not, take the time to acknowledge the child's feelings with simple, clear statements. Samples include: "This must seem scary to you" or "This is not your fault." Taking the time to validate what the child may be feeling is important to the child's understanding of what is happening around him or her.

The long-term effects of domestic violence on children can be devastating. Like sponges, children may soak up the adults' problem-solving techniques. If no actions are taken against the perpetrator, children may imitate violent behavior because that is what is common in their household and there appears to be no negative results. It is estimated that male children who witness abuse are more likely to assault their mates when they grow up. Witnesses of domestic violence learn that violence is an acceptable way to deal with

conflict, and may assume that violence is the norm. Children in a family in which their mother is being abused learn both the victim role and the aggressor role. This perpetuates the cycle of violence as children and then as adults.

Children also exhibit physical conditions, including headaches, stomach problems, or diarrhea. Other physical responses to witnessing domestic violence get worse around bedtime and include sleepwalking, bed-wetting, nightmares, separation anxiety, clinginess, and insomnia. Behavioral responses may include aggressive behavior with other children, adults, or animals; regression in developmental behaviors already mastered, excessive crying, withdrawal or fantasy life, emotional neediness, over compliance, extreme passivity, self-mutilation, school problems and delinquency.

Studies have shown that children who personally witness violence are four times more likely to develop patterns of violent behavior later on in life. As the child matures into adolescence, these consequences may become more entrenched and more severe, including the ideation of suicide, substance abuse, depression, feelings of hopelessness, chronic anxiety, difficulty controlling anger, early marriage and early pregnancy. These children may be further victimized or blamed for having a psychological or behavioral problem, rather than receiving validation and support in coping with family problems.

When responding to domestic violence scenes that involve children, remember:

Your role as emergency care providers is to primarily provide medical care. You are not expected to be a counselor or therapist. However, your recognition of other potential dangers can help you encourage and support the victim to take the necessary steps to stop the violence against herself and other family members.

LEGAL ASPECTS OF DOMESTIC VIOLENCE

EMS personnel respond to scenes of domestic violence, oftentimes knowingly but sometimes not. While the primary purpose of EMS is to provide medical care to the patients of these calls, it is important that the EMT has a basic understanding of some critical legal aspects of domestic violence scenes. Your understanding of the legal aspects will help you give appropriate information regarding different legal actions and what the victim may expect if a particular legal course of action is pursued. When you respond to a domestic violence call, it is not only a medical scene but it is a crime scene as well. As a result, you may be subpoenaed as a witness if the case goes to trial.

Alaska state statute (AS 18.66.990) defines domestic violence as one or more of the following offenses or a law or ordinance of another jurisdiction having elements similar to these offenses, or an attempt to commit the offense, by a household member against another household member:

- ⇒ a crime against the person;
- ⇒ burglary;
- ⇒ criminal trespass;
- ⇒ arson or criminally negligent burning;
- ⇒ criminal mischief;
- ⇒ terroristic threatening;
- ⇒ violating a domestic violence protective order; or
- ⇒ harassment.

The definition of household members includes:

- ⇒ spouse, former spouse;
- ⇒ persons who live together or have lived together;
- ⇒ persons who are dating or who have dated;
- ⇒ persons who are engaging in or who have engaged in a sexual relationship;
- ⇒ persons who are related to each other up to the fourth degree of consanguinity, whether of the whole or half blood or by adoption;
- ⇒ persons who are related or formerly related by marriage;
- ⇒ persons who have a child of the relationship;
- ⇒ minor children of a person in a relationship that is described earlier.

Please realize that this section provides a broad overview of the legal components in responding to a domestic violence scene. The above information is not definitive. It is meant to introduce you to a larger scope of a problem, within which EMS plays a specific and important role. If you have additional questions, please refer to the resources at the end of this module.

PREVENTION STRATEGIES

The causes and effects of domestic violence are rooted in social issues that often seem beyond our control. In Alaska, the issues of rural access and cultural diversity add many challenges in our efforts to address the problems of domestic violence. Despite myriad problems, our state has made significant headway in providing resources to identify and prevent domestic violence. The very fact that this information is now provided to pre-hospital providers indicates an increased awareness and desire to respond to the problems of domestic violence.

One of the most important aspects of preventing domestic violence is identification of the issue. The first, manageable step to preventing domestic violence is identifying the victims. We all can begin the empowerment of the victim by asking “Domestic violence is such a serious health problem that I ask all my patients: Has someone you know caused these injuries?” By asking this question, we begin the process of healing.

The second most important aspect of preventing domestic violence is referring victims to resources that are available to help her cope and respond to her situation. The decision to call police, pursue legal action, or access resources rests entirely with the battered person. It is his or her decision to act; however, we can help make the victim aware of resources and support systems. By heightening your own awareness in identifying domestic violence and offering support services that are available to the victim, you can acknowledge she is not alone, that she does not deserve the violence, and that there are resources to help her when she decides to leave the batterer.

The third point in preventing domestic violence is recognizing potential factors that may allow or accept violence in our own lives and our community. For example, as health care professionals, we can examine our own behavior and educate ourselves and our friends on violence-related issues. We can give careful consideration to the content and messages of movies and television. We can encourage youth to avoid violence as a response. We can support programs that offer conflict resolution strategies other than violence. We can teach youth that violence against them is unacceptable. We can offer to speak or present to youth or school groups on the violence we see as part of our work.

Other specific resources in Alaska include the following:

Alaska Family Violence Prevention Project (AFVPP) is with the State of Alaska, Department of Health and Social Services, Section of Maternal, Child, and Family Health. Formerly known as the Alaska Domestic Violence Training Project, they provide multidisciplinary training on domestic violence for health care and service providers. Training topics include assessment, indicators, intervention, documentation and referrals for women who have been abused. If you are interested in training or have questions, please contact Linda Chamberlain at (907) 269-3400/3453 or 1-800-799-7570.

Division of Family and Youth Services (DFYS). EMS responders are required by law to report all suspected cases of child abuse or neglect to DFYS. Their toll free number is 1-800-478-4444. DFYS must, by law, investigate all reports of suspected child abuse or neglect. If the agency finds the report unfounded, that will end the investigation. If, however, the individual investigating the report believes that the child is in need of protective services (and the family is in need of services), a program on in-home support services can be determined to help stop the abuse or neglect. If it is determined that the child is in need of emergency protection, the social worker can immediately take custody of the child and remove the child to a place of safety. This would only be temporary placement. Permanent foster placement or out-of-home placement and termination of parental rights can be done only through court action.

Alaska Network on Domestic Violence and Sexual Assault is a non-profit network of over twenty programs throughout the state. These programs provide direct services to victims of domestic violence and sexual assault and their families. Services include shelters, crisis intervention, transportation, counseling for adults and children, support/advocacy, and referrals. The Network also provides training and technical assistance to professionals and lay citizens who work with victims of domestic violence and sexual assault. For more

information regarding training and technical assistance call (907) 586-3650. (Regional program information is contained in the appendices).

Alaska Council on Domestic Violence and Sexual Assault was established in the Department of Public Safety in 1981. The purpose of the Council is “to provide planning and coordination of services to victims of domestic violence and sexual assault or to their families and to perpetrators of domestic violence and sexual assault, and to provide for crisis intervention and prevention program.” Its statutory duties include:

- funding and maintaining domestic violence and sexual assault programs;
- provision for planning of services to victims of domestic violence or sexual assault, their families and perpetrators of domestic violence and sexual assault;
- coordination of domestic violence and sexual assault services provided by state agencies and community groups;
- development and implementation of a standardized data collection system; and
- provision, of fiscal and technical assistance to domestic violence and sexual assault programs.

Adult Protective Services, Division of Senior Services, provides services that prevent or stop harm from occurring to vulnerable adults. Vulnerable adults have a physical or mental impairment or condition that prevents them from protecting themselves or from seeking help from someone else. Alaska law defines vulnerable adults to include adults 18 years of age or older, not just the elderly. The harm they suffer may result from abandonment, abuse, exploitation, neglect or self-neglect. Reports should be made to the central reporting number for the Division of Senior Services within 24 hours at 1-800-478-9996. Reports also can be made to local law enforcement agencies if a report cannot be made to the division. Local law enforcement agencies are mandated to investigate and take appropriate action to protect vulnerable adults.

SUMMARY

You, as a pre-hospital health care provider, may be the first or only professional with whom a victim of domestic violence may have contact. In addition to patient care, you need to use your powers of observation to be able to “read between the lines” and be alert for clues.

When EMS personnel do suspect a violent -- or potentially violent -- situation, you should inform law enforcement and the emergency department staff of the situation. Safety for you, the victim and the children are the top priorities in these situations. Educate yourself about domestic violence. Given the magnitude of the epidemic of intimate violence in our country, it is likely that not only are our patients affected by the problem, but also that someone in your family, your neighborhood, or your workplace is being abused. Your sensitive questions and offer to help may be the impetus needed to turn these problems around.

EMS Response to Domestic Violence

Appendices

Facts About Family Violence

Family violence is a pervasive problem in the U.S. Because most family violence occurs in the home behind closed doors, it is difficult to collect data on the extent and patterns of such violence. Estimates are based on information from several sources: clinical observations and case reports; community surveys; crime reports; psychological evaluations; and interviews with victims and perpetrators.

INTIMATE AND SPOUSAL ABUSE

- Nearly one in every three adult women experiences at least one physical assault by a partner during adulthood.
- Approximately four million American women experience a serious assault by an intimate partner during a 12-month period.
- Six times as many women who experience violence by an intimate partner (18 percent) as by a stranger (three percent) do not report the crime.
- Several types of violence and abuse usually occur within the family; men who batter their intimate partners are more likely to abuse their children too.

Risk Factors

- Perpetrators of violence usually have problems with power and control and a history of physical or sexual abuse, or threats of abuse.
- Battered women and their abusers come from all demographic groups; there is no single psychological profile of either; and the only risk factor they both share is exposure to violence between parents.
- Both victims and perpetrators of domestic violence have a tendency to abuse alcohol. Excessive alcohol use is more than 50 percent for male batterers and around 20 percent for women victims.
- The highest risk for serious injury or death from violence in an intimate relationship is at the point of separation or at the time when the decision to separate is made.

CHILD ABUSE

- Men are the leading perpetrators of the physical and sexual abuse of children. When neglect is included, then the proportion of male and female abusers are the same.
- Abuse accounts for about 10 percent of the injuries to children under the age of seven who are examined in emergency rooms.
- Approximately 1,300 children died as a result of child abuse and neglect in 1993; an estimated 2.9 million cases of suspected child abuse and neglect were reported to authorities and an estimated one million of these cases were confirmed by child protective services.
- Fifty-seven percent of children under 12 who are murdered are killed by a parent; each year, an estimated 3.3 million children are exposed to violence by family members against their mothers or female caretakers; and 16-34 percent of girls

and 10-20 percent of boys are sexually abused, mostly by a family member or trusted family friend.

Risk Factors

- The best predictor of future violence is previous violence - children who experience multiple acts of violence or more than one kind of violence are at a greater risk of continuing the "cycle of violence."
- Unwanted children and children with physical or mental disabilities are at risk for abuse.
- Parents or caretakers who experience a combination of stress, like having more than four children, living in poverty (annual income \$15,000 and under), abusing drugs, being a young mother or being isolated from others outside the family are at much greater risk to maltreat their children.

ELDER ABUSE

Few studies have looked at elder abuse, and this type of abuse is rarely reported. However, a 1994 study of case reports to protective agencies by the National Center on Elder Abuse found that neglect is the most common form of elder maltreatment in domestic settings and that adult children are the most frequent abusers of the elderly. Reports of elder abuse have more than doubled (from 117,000 to 241,000) in the last ten years.

- Nearly a third of the murders of persons aged 60 or older are committed by a family member.
- Most of the abuse against the elderly is committed by someone they live with, and state reporting systems show that adult children are the most frequent abusers of the elderly.
- Because most caregivers for the elderly are women, most of the neglect cases are committed by female family members; however, the male family members are the most frequent perpetrators of physical abuse against the elderly.

Risk Factors

- Abusers usually have a history of personal problems or pathology and/or may be financially or emotionally dependent on the older person.
- Men who abuse their elderly partners may be continuing a pattern of abuse that has been going on throughout the lifecycle, or they may start abuse because of an emotional disorder or organic brain deterioration.

SOURCE: American Psychological Association

EMS SAFETY AT SCENES OF DOMESTIC VIOLENCE

En route to call

1. Have police been dispatched? How far away are they?
2. Have there been comparable calls to this residence in the past?
3. Are both you and your partner prepared and equipped for this call? Preparation includes not only equipment, but also mental and emotional preparedness. Have you and your partner practiced what to do in potentially dangerous scenes?

Approach of the scene

1. Approach with your sirens and lights off. Stop your vehicle a half mile from the scene to gather additional clues before stepping from your rig.
2. What clues are evident before stepping out of your rig:
 - a. Are there items in the yard or driveway that indicate children might be present?
 - b. Are there any indications that firearms may be present at this residence (e.g., a gun rack or bumper stickers on a vehicle)?
 - c. If at night, what lights are on in the house?
3. Is your vehicle parked so that an escape route is available if needed?
4. What is the level of noise at the residence? Is there yelling, screaming, or sounds of struggle?

Entry into the residence

1. Don't stand in front of the open door. As you enter a room, turn on the lights. Leave lights on in every room if possible.
2. Are there indications of alcohol or drug use at this residence?
3. Visually frisk everyone for possible weapons when you enter.
4. Identify how many people are in the residence and where they are located. Are there neighbors that could be asked to leave. The less people, the better. Never walk down a hallway with someone behind you. Let them lead.
5. If at all possible, do not work on people in kitchens or bedrooms:
 - a. Kitchens have numerous and a variety of weapons, including knives, heavy cooking pots, boiling water, glassware.
 - b. Bedrooms usually do not have an exit or escape route. Many people keep concealed, loaded handguns in the bedroom. Finally, if the perpetrator has jealous nature, the bedroom may be viewed as an intimate and therefore; threatening place.
6. Do not assume that just because the offender has been arrested at the scene, that the situation is under control. The victim or members of the family, even children, have been known to assault police and EMS personnel. Always stay alert!
7. Keep your partner in sight at all times.
8. Maintain link with your dispatch or communication system.
9. Determine location and condition of victim, and separate suspect and perpetrator, if still at scene. Interview victim and any witnesses separately, especially if both are injured.
10. Keep your exit path open at all times.

EMERGENCY MEDICAL SERVICES DOMESTIC VIOLENCE INDICATORS OR RED FLAGS

Patient is fearful of household member or exhibits increased anxiety when member is near.

Patient is reluctant to respond when questioned or hesitates in providing information about how the injury occurred.

Patient is in an unusually isolated, unhealthy, or unsafe living environment.

Patient admits to frequent use of tranquilizers, sleep medication, illicit drugs or alcohol.

Patient and other household members give conflicting accounts of incident.

Patient offers history that is inconsistent with the injury or illness.

Patient presents with multiple vague complaints, such as headache, insomnia, pseudo-seizures, abdominal discomfort, and muscle ache or non-specific pain.

Patient presents with injuries during pregnancy.

Patient complains of trauma without anatomic “evidence of injury.”

Patient exhibits old injuries or injuries in various stages of healing, particularly to the back, neck, and ribs.

Household member is angry or indifferent towards patient and refuses to provide necessary assistance.

Household member refuses or hesitates to permit patient’s transport to hospital.

Household members seek to prevent the patient from interacting privately or speaking openly.

Household member appears concerned about a minor patient problem but not the patient’s serious health issue.

There are unexplained delays in seeking treatment for injury.

Police/EMS have responded to scene previously or repeatedly.

IDENTIFYING A VICTIM OF DOMESTIC VIOLENCE

One of the most difficult steps a battered woman must take is to identify herself as a victim. Although experiences may differ, this checklist may help determine if she is battered.

Does her partner:

- ___ constantly criticize her and her abilities as a wife or partner or mother?
- ___ behave in an over-protective manner or become extremely jealous?
- ___ threaten to hurt her, her children, pets, family members, friends, or himself?
- ___ prevent her from seeing family or friends?
- ___ get suddenly or uncontrollably angry or lose his temper?
- ___ deny her access to family assets such as bank accounts, credit cards, or car?
- ___ control all finances and requires her to account for what she spends?
- ___ control most of her daily activities, controlling where she can or cannot go?
- ___ use intimidation or manipulation to control her or her children?
- ___ prevent her from going where she wants to when she wants to?
- ___ force her to have sex that makes her uncomfortable?
- ___ humiliate or embarrass her in front of others?
- ___ abuse alcohol or street drugs?
- ___ threaten to kill her?

If the answer is “yes” to any of these questions, she may be a victim of domestic violence. She is not to blame. She is not alone. Millions of women are abused by their partners and often don’t know that help is available.

DOMESTIC VIOLENCE PERSONAL SAFETY PLAN

SAFETY PLAN WHILE PREPARING TO LEAVE

- ◆ Open a savings or credit card account in your own name to increase your independence.
- ◆ Pack an overnight bag (see checklist below) with essentials and leave with someone you trust so that you can leave quickly.
- ◆ Determine where you can stay and who might be able to lend you some money.
- ◆ Decide where you will go and how you will get there if you need to leave home.
- ◆ Tell those whom you can trust about the violence.
- ◆ Develop a code word with your children or neighbors that lets them know that you need to get out now and they need to call the police.
- ◆ Document visits with the doctor, calls to the police, trips to the shelter, and any other help which you seek to stop the violence.
- ◆ Maintain positive thoughts about yourself, and assert your needs with others. Read books or articles that help you feel stronger.
- ◆ Keep close at hand the shelter or hotline phone number, as well as loose change or an extra phone card to make a phone call.
- ◆ Review your safety plan often so that, when it comes time to leave, you will know what to do.
- ◆ Remember, leave-taking is the most dangerous time of all.

CHECKLIST: WHAT TO TAKE WITH YOU WHEN YOU LEAVE

Identification:

- * Driver's license
- * Children's birth certificates
- * Your own birth certificate
- * Social security card

Legal:

- * Your restraining order
- * Rental agreement or house deed
- * Car registration and insurance
- * Health and life insurance papers
- * Medical records for you/your children
- * Work permit, green card, passport
- * Divorce and custody papers

Financial Items:

- * Money
- * Credit Cards
- * Bankbook or checkbook

Other Essentials:

- * House and car keys
- * Toiletries
- * Change of clothes
- * Phone card
- * Pictures of you, your children and your abuser
- * Medications
- * Jewelry
- * Address book
- * Small toys for the children

DOMESTIC VIOLENCE QUESTIONS EVERY PROVIDER NEEDS TO ASK

S

DO YOU FEEL **SAFE** IN YOUR
RELATIONSHIP/MARRIAGE? SHOULD I BE
CONCERNED FOR YOUR **SAFETY**?

A

ARE THERE SITUATIONS IN THE
RELATIONSHIP WHERE YOU HAVE FELT
AFRAID? WHAT HAPPENS WHEN YOU AND
YOUR PARTNER DISAGREE OR **ARGUE**?

F

ARE YOUR **FRIENDS** AWARE THAT YOU
HAVE BEEN HURT? DO YOUR **FAMILY**
MEMBERS KNOW ABOUT THIS ABUSE? WOULD
FAMILY OR **FRIENDS** BE ABLE TO HELP OR
SUPPORT YOU?

E

DO YOU HAVE A SAFE PLACE TO GO IN AN
EMERGENCY? IF YOU NEEDED TO LEAVE NOW,
DO YOU HAVE AN **ESCAPE PLAN**? WOULD YOU
LIKE TO TALK WITH AN ADVOCATE TO
DEVELOP AN **EMERGENCY SAFETY PLAN**?

RESPONDING TO A DOMESTIC VIOLENCE PATIENT

If a patient answers YES to a question of suspected domestic violence, the following steps are suggested:

Encourage her to talk about it in a confidential setting. Ask your patient if she would like to talk about what has happened, how she is feeling, and what she would like to do next. Listen non-judgmentally. Emphasize the violence is not her fault. Allow an environment to begin the healing process. This will give you an idea of what kind of referrals your patient is receptive to.

Validate your patient. Victims of domestic violence are frequently not believed, and they believe that their fear is minimized. You can express concern and support through simple statements such as:

- You are not alone.
- You don't deserve to be treated this way.
- You are not to blame.
- You are not crazy.
- What happened to you is a crime.
- Help is available to you.

Document what has been done and said. Note patient's complaints and symptoms. Complaints should be described in the patient's own words when possible. Write a description of the injuries, including type, size, location, resolution, possible causes, and explanations given. Use a body map (sample attached). Make note if the injuries are inconsistent with the patient's explanation.

Assess the danger to your patient. Assess your patient's safety before she leaves the medical setting. Convey your concern that the violence against her will recur and may increase. The most important determinants of risk are the woman's level of fear and her appraisal of her immediate or future safety. Discuss the following indicators with the patient to determine if she may be in escalating danger:

- Has there been an increase in the frequency or severity of the assaults?
- Are there increasing or new threats of homicide or suicide by the partner?
- Has the perpetrator threatened her children?
- Is there a firearm present or readily available?

Treat the patient's injuries. Provide appropriate treatment referral. If the patient is in imminent danger, determine if she has friends or family with whom she can stay. If this is not an option, ask if she wants immediate access to a shelter. If she doesn't need immediate access to shelter, offer information about shelters or community resources. It may be dangerous for the women to have this information in her possession; don't insist

RESPONDING TO A DOMESTIC VIOLENCE PATIENT, Cont.

she take them if she is reluctant. If she does accept written information, write the telephone number without the name of the support service. Encourage her to tuck it in her shoe. Don't push her to leave if she is clearly telling you she is not ready to do so.

If the patient answers NO to a question of suspected domestic violence, or will not discuss the topic:

Be aware of clinical findings that may indicate abuse such as:

- injury to the head, neck, torso, breasts, abdomen, or genitalia;
- multiple injuries;
- delay between onset of injury and seeking treatment;
- explanation by the patient that is inconsistent with the type of injury;
- any injury during pregnancy, especially to the abdomen or breasts;
- chronic pain symptoms for which the source is unknown;
- psychological distress, such as depression, suicidal ideation, anxiety, sleep disorders;
- a partner who seems overly protective or who will not leave the woman's side.

If any of the above clinical signs are present, it is appropriate to ask specific questions. Be sure that the patient's partner is not present. Some example questions that may elicit more information about the patient's situation are:

- It looks as though someone may have hurt you. Can you tell me how this happened?
- Sometimes when people call 9-1-1 with physical symptoms such as yours, we find that there may be trouble at home. We are concerned that someone may be hurting you. Is this happening?
- Sometimes when people feel the way you do, it's because they may have been hurt or abused by someone they love. Is this happening to you?

If the patient answers no and you strongly suspect that abuse has taken place, you can still provide referrals to local programs. Write the number of the domestic hotline on a blank piece of paper. Make sure you document inconsistencies between what the patient reports and the injuries.

WHAT TO LOOK FOR

Common Diagnoses/Clinical Indicators

Signs of Physical Abuse

Injuries most commonly involve the head, neck, chest and abdomen. Trauma to the genital area is also commonly observed. During pregnancy, the breasts and abdomen are particularly common injury sites.

Nature and Circumstances of Injuries Suspect of Abuse

- ⇒ Injury inconsistent with history;
- ⇒ Numerous injuries at multiple sites in absence of catastrophic event (motor vehicle crash, etc.);
- ⇒ Injuries in multiple stages of healing; old and often untreated injuries often evident;
- ⇒ Repeated or chronic injuries;
- ⇒ Patterned injuries such as belt buckles, fist marks, heel/shoe mark from kicking or stepping on the victim's back or abdomen;
- ⇒ Bilateral injuries (e.g., bruises on both forearms);
- ⇒ Delay in seeking medical care for injury;
- ⇒ Partner unwilling to leave woman alone in treatment, anxious to answer all questions directed to patient.

Head and Spinal Injuries

- ⇒ Serious head injuries are common;
- ⇒ Mild traumatic head injury from cumulative trauma such as repeatedly being shoved/slammed against a wall; slurred speech and hearing deficits are commonly observed;
- ⇒ Back/spinal injuries as a result of being pushed, shoved or thrown, often repeatedly; these injuries often resemble what is seen with fall-related injuries but the nature and circumstances of the injury reveal that the injury was inflicted (e.g., patient has other injuries not likely to be caused by a fall);
- ⇒ Ruptured ear drums as a result of blows to the head/ears.

Sprains and Fractures

- ⇒ Fractures associated with falls due to being pushed and/or shoved;
- ⇒ Fractures of the forearm are commonly seen as woman attempts to shield herself with her arms;
- ⇒ Facial and orbital fractures from direct blows to the area of the eyes.

Contusions, Bruises and Lacerations

- ⇒ Proximal or central bruising on the body, often in hidden areas covered by clothing is highly suspicious for abuse (e.g. bruises on inner thighs);
- ⇒ Black eye(s);
- ⇒ Facial lacerations: frequently a U-shaped cut is observed with bruising due to a ring that the abuser had on when he hit/punched the victim;

- ⇒ Cuts and slashes: often observed on a victim's hand/wrist area as she attempts to defend herself from a knife;
- ⇒ Neck burns and strangulation marks around the throat/neck;
- ⇒ Finger marks: often observed on inner soft tissue of the legs and/or arms from the abuser holding the victim down (during sexual assault, beating, etc.).

Burns and Bites

- ⇒ Burns: often from a cigarette, iron or radiator, commonly involving the hands, feet;
- ⇒ Friction burns from being restrained, dragged (e.g., rope burns);
- ⇒ Human bite marks.

Self-Inflicted Injuries

- ⇒ Abused women are at very high risk for suicide and suicide attempts;
- ⇒ Self-induced or attempted abortions.

Signs of Sexual Abuse

- ⇒ Frequent vaginal and urinary tract infections; difficulty/painful urination, pain during sexual intercourse;
- ⇒ Chronic pelvic pain;
- ⇒ Pelvic inflammatory disease (PID) with negative lab finding;
- ⇒ Recurrent sexually transmitted diseases (STDs): the batterer may force his partner to have unsafe sex;
- ⇒ Irregular vaginal bleeding;
- ⇒ Pain and fear upon examination; vaginismus (very tense vaginal muscles when exam attempted);
- ⇒ Poor contraceptive compliance and/or multiple therapeutic abortions: the batterer may forbid use of contraceptives and family planning;
- ⇒ Sexual dysfunction.

Medical Signs During Pregnancy

- ⇒ Any injury during pregnancy, particularly injuries to the breasts, abdomen and genital area;
- ⇒ Pre-term abortions, bleeding, miscarriages and premature labor: abused women are at significantly higher risk of having intrauterine growth retardation and low-birth weight infants;
- ⇒ Hyperemesis (excessive vomiting);
- ⇒ Substance abuse, poor nutrition or depression;
- ⇒ Late or sporadic prenatal care: the abuser restrains the woman from obtaining prenatal care.

Related Medical Findings

- ⇒ Chronic pain syndrome due to diffuse, repetitive trauma (no evidence of visible injury may be present at time of examination);

- ⇒ Recurrent sinus infections and/or dental problems secondary to facial trauma;
- ⇒ Physical symptoms related to stress, chronic post-traumatic stress disorder, other anxiety disorders or depression. Examples are:
 - panic attacks
 - eating disorders; malnutrition
 - chronic headaches
 - abdominal and gastrointestinal complaints
 - numbness and tingling (parasthesia)
 - atypical chest pain
 - frequent visits with vague complaints or symptoms without evidence of physiologic abnormality;
- ⇒ Frequent use of prescribed tranquilizers or pain medications.

Mental Health/Psychiatric Symptoms

- ⇒ Depression;
- ⇒ Substance abuse;
- ⇒ Post-traumatic stress reactions/disorders;
- ⇒ Suicide attempts or gestures.

Patients and Partners Behavioral Signs

- ⇒ Patient's anxiety or distress is out of proportion to the severity of injuries or complaints;
- ⇒ Patient is reluctant to speak in front of her partner;
- ⇒ The partner accompanies patient, stays close and answers questions directed to her;
- ⇒ Denial or minimization of violence by partner or patient;
- ⇒ Intense jealousy or possessiveness demonstrated by partner or reported by patient;
- ⇒ Self-blame by patient for abuser's violence.

Issues for Treatment

An abuser's pattern of controlling and intimidating his partner creates the following obstacles to treatment:

- ⇒ Limited access to routine and/or emergency medical care; missed appointments;
- ⇒ Noncompliance with treatment: not allowed to obtain or take medication.

Dental Setting Common Diagnostic Indicators of Abuse

Orofacial/Dental Trauma

- ⇒ Facial bruises and injuries (e.g., strangulation marks, black eye, split lips);
- ⇒ Fractured, partially dislocated, chipped or missing teeth;
- ⇒ Fractures of the cheekbones and orbital fractures;
- ⇒ Fractures of the upper and lower jaw, palate and nasal bones;

- ⇒ Lacerations of the oral mucosa;
- ⇒ Burns or bruises of the gums, palate and face.

Chronic Pain Syndromes Due to Cumulative Trauma

- ⇒ Temporomandibular pain;
- ⇒ Chronic face pain;
- ⇒ Permanent hearing loss.

Tissue Lesions

- ⇒ Oral signs of sexually transmissible disease
 - Gonococcal infections of the pharynx
 - Syphilis
 - Herpes
 - Chlamydial infections
 - Candidiasis
- ⇒ Related to malnutrition/nutritional deficiencies
 - Cheilosis
 - Angular stomatitis
- ⇒ Related to stress and/or poor oral hygiene
 - Acute necrotizing ulcerative gingivitis

Source: ONE IN FIVE WOMEN, Alaska Network on Domestic Violence and Sexual Assault

How to Talk with Someone Who Is Being Abused

Guidelines for Co-Workers

“I think one of my co-workers may be experiencing domestic violence...What should I do?”

You might feel awkward bringing up domestic violence with a co-worker. That's a natural reaction. And you don't want to put her on the spot if she's not ready to talk. But you can let her know that you support her.

If your co-worker has unexplained bruises, or explanations that just don't add up, if she is distracted, has trouble concentrating, misses work often, or receives repeated, upsetting telephone calls during the day, she may be in an abusive relationship.

Guidelines for Co-Workers:

Many people hesitate to speak with women who they think are being abused because they don't quite know what to say, or how to say it. Relax and be yourself and you'll automatically communicate what's important: your concern.

You may hesitate to get involved because you see domestic violence as a personal matter, and because what goes on away from work isn't your business. But many women find it hard to ask for help, especially when they have reached out for help in the past and have been blamed for the violence instead. Most battered women who are offered help deeply appreciate it, even if they don't say so. For many women it takes a lot of time, planning, help and courage to escape the violence. In the meantime, it is important for women to know that help is available from people who know and care about the situation. Knowing that people are out there offering help makes it much easier for women to take action.

So if you know someone who is being abused by her husband or boyfriend, there are many things you can do that will make a real difference.

How do you know something is wrong?

There are lots of ways you can tell if something is wrong. Perhaps your co-worker often has unexplained injuries. She may appear anxious, upset or depressed. The quality of her work may fluctuate for no apparent reason. She may also be receiving a lot of harassing phone calls or faxes. She may become upset when she gets calls from her husband or boyfriend. Or she might have a high absenteeism rate, due to frequent medical problems and fears about leaving children at home alone with the abuser.

How you can lend a hand:

- Establish a rapport with her if you don't already have one, so that she feels comfortable talking with you and you do not put her on the spot.
- Listen, without judging. Often a battered woman believes her abuser's negative messages about herself. She may feel responsible, ashamed, inadequate, and afraid she will be judged by you.
- Let her know that you care about her. Tell her she is not responsible for the abuse. Explain that physical violence in a relationship is never acceptable. There's no excuse for it – not alcohol or drugs, financial pressure, depression, jealousy, or any behavior of hers.
- Make sure she knows she is not alone. Millions of women of every age, race and religion face abuse, and many women find it extremely difficult to deal with the violence. Emphasize

that when she wants help, it is available. (Call 1-800-799-SAFE, the National Domestic Violence Hotline, to find local resources.) Let her know that domestic violence tends to get worse and become more frequent with time, and that it does not go away on its own.

- Explain that domestic violence is a crime – as much of a crime as robbery or rape – and that she can seek protection from the police or courts, and help from a domestic violence program. Give her phone numbers she can call for help and referrals.
- Give her written materials about what she can do to protect herself. Local shelters have this kind of information.
- If you want to talk with someone yourself to get advice, contact a local domestic violence program. They can help you figure out what is best to do in your situation.

What if she decides to remain in the relationship?

- Many women remain in the relationship, and try to get help for their abusers. Remember that, for many women, separating from an abusive partner is a process and not an event, and takes time. Realize that often the most dangerous time for a woman is when she threatens the batterer's control by attempting to leave.
- Respect the employee's boundaries and privacy, even if you disagree with the decisions she is making regarding the relationship, because leaving is often difficult because of financial and childcare responsibilities, or threats of violence. Be patient and understanding.
- Encourage her to call a domestic violence hotline or Employee Assistance Program to get help developing a safety plan.
- Suggest she tell her doctor or nurse about the violence, asking him or her to document the abuse in her medical records and take photographs of her injuries. Suggest she store them in a safe place, along with a written description of what happened. These records may be helpful to her if she decides to take legal action in the future.

What if she decides to leave?

If she decides to leave her relationship, she may need money, help finding a place to live, a place to store her belongings, or help getting to a battered women's shelter. The most important thing you can do is help her develop a safety plan, which includes setting aside money and important documents in a safe place and a making a plan to increase her safety. Domestic violence programs can help. Make sure she knows about all of the safeguards and assistance that the workplace can offer her, which might include security escorts to her car, priority parking near the building, temporary assignments in other locations, or time off from work.

Regardless of her decisions or actions, respect confidentiality in all your discussions with her.

What if I Am a Domestic Violence Survivor or Grew Up in a Violent Home? Is There Anything Special I Can Do?

If you have first hand experience with domestic violence, the best thing you can do is tell your story to others. Let friends, co-workers and your community know about your experience and expertise in this area. Let other women see the life you have built as a survivor. Being open about what you went through or witnessed also helps remove the stigma of being abused.

SOURCE: Work to End Domestic Violence

WHY SOME VICTIMS STAY/WHEN THEY LEAVE

One of the most commonly asked questions about domestic violence is, “Why do victims stay in violent relationships?” The reality is that many victims leave. But it is a process.

The primary reason given by victims of domestic violence for staying or returning to the batterer is **fear of violence and lack of real options for safety with their children.**

This fear of violence is realistic. Research has shown that the violence against women often increases when the batterer believes that the victim has left or is about to leave the relationship.

The reasons for staying in a violent relationship are multiple and vary for each victim. They include:

1. Fear of batterer’s violence;
2. Immobilization by psychological and physical trauma;
3. Connection to the batterer through his access to the children;
4. Illness and dependence on the batterer for health care;
5. Belief in cultural/family/religious values that encourage the maintenance of the family unit at all costs;
6. Continual hope and belief in the batterer’s promises to change and to stop being violent;
7. Belief that the batterer cannot survive (e.g., due to illness with AIDS) or will engage in self-destructive behavior if the victim leaves;
8. Insufficient funding and resources nationwide that result in a lack of shelters and victim advocacy programs to provide transitional support;
9. Lack of real alternatives for employment and financial assistance, especially for victims with children;
10. Lack of affordable legal assistance necessary to obtain a divorce, custody order, restraining order, or protection order;
11. Lack of affordable housing that would provide safety for the victim and children;
12. Being told by others that the abuse is happening because the victim is gay, lesbian, or bisexual and that the abuse would stop if they would "change"; and
13. Being told by the batterer, counselors, the courts, police, ministers, family members, or friends that the violence is the victim’s fault, and that the victim could stop the abuse simply by complying with the batterer’s demands.

CULTURAL DIVERSITY

The population of Alaska reflects a broad and rich diversity of cultures and ethnicity. This variety can make the delivery of EMS care difficult or frustrating. It may help to remember that YOUR way of doing something is not the only way. This is especially meaningful when responding to domestic violence scenes and victims. The following are offered as a basic format to incorporate cultural diversity within your profession.

- * Accept cross-cultural awareness as a professional skill.
- * Expect cross-cultural competency as part of your EMS job performance.
- * Recognize that each community has cultural norms that may be different from yours.
- * Identify your own issues -- biases, prejudices, previous experiences -- and be able to put them reliably on the back burner while you are providing care.
- * Pay attention to gender issues and how they work or don't work culturally.
- * Find the least intrusive level of response or intervention and start there.
- * Ask up-front for guidance if you are dealing with another culture.
- * Experience yourself as an alien, a mindset where you pause and question everything you do.

NUTS AND BOLTS

- * Be humble.
- * Don't walk in the door talking.
- * Introduce yourself. Make it real, not canned.
- * Clean up after yourself. Show respect for their world.
- * Ask the minimum number of questions, in non-threatening tones.
- * Do not respond to intimidation.
- * Count to three before answering any question.
- * If you're getting resistance, step back and let somebody else step in.
- * Know what you know, what you don't know, and don't pretend otherwise.
- * Don't order people around.
- * Taking a second more will not cost you the incident.
- * Pre-train and re-train:
 - * Cross-cultural
 - * Confrontation and stress management
 - * Team building
- * Include local customs in your protocols.
- * Don't ever say "you people."
- * If a teammate blunders, apologize for them.
- * Rehearse these skills in your training.
- * Learn your partner's yuks!
- * Be clear when there is something you must do that goes against custom.
- * Acknowledge conflict.

Adapted from A. HORNE & KELFORD/DUKES FOR HONOLULU CISD, 1991

MYTHS ABOUT LESBIAN AND GAY DOMESTIC VIOLENCE

Only heterosexual women get battered. Men are never victims of domestic violence and women do not abuse.

Domestic violence is more common in heterosexual relationships than in lesbian or gay male relationships.

It isn't violence when a same-sex couple fights. It is a lover's quarrel, a fair fight between equals.

It isn't really violence at all when gay men fight -- it's just boys being boys.

The batterer will always be butch, bigger, and stronger. The victim will always be feminine, smaller, and weaker.

People who are abusive under the influence of drugs or alcohol are not responsible for their actions.

Gay men's domestic violence has increased as a result of alcoholism, drug abuse and the AIDS epidemic.

Lesbian and gay domestic violence is sexual behavior, a version of sado-masochism. The victims actually like it.

The law does not and will not protect victims of lesbian and gay men's domestic violence.

Lesbian and gay male victims exaggerate the violence that happens to them. If it were really that bad, they could just leave.

It is easier for lesbian or gay victims of domestic violence to leave the abuser than it is for heterosexual battered women.

Domestic violence primarily occurs among gay men and lesbians, who hang out at bars, are poor, or are people of color.

Victims often provoke the violence done to them. They are getting what they deserve.

Lesbian or gay male victims of domestic violence are co-dependent.

THE ABOVE STATEMENTS ARE MYTHS. THEY ARE NOT TRUE.

Adapted from the National Lesbian and Gay Health Foundation Conference, July 1990

SAME SEX DOMESTIC VIOLENCE

How is lesbian and gay battering **similar** to battering in heterosexual relationships?

- * No one deserves to be abused.
- * Abuse can be physical, sexual, verbal, emotional, or psychological.
- * Abuse is a pattern of behavior designed to maintain control over one's partner.
- * Abuse often occurs in a cyclic fashion.
- * Abuse can be lethal.
- * The abused partner feels isolated, afraid, and usually convinced that they are at fault.
- * The incidence rate in relationships for gay and lesbian battering and heterosexual battering is approximately the same.

How is lesbian and gay battering "**different**" from heterosexual battering?

- * Lesbians and gay men who are abused have much more difficulty finding appropriate support than heterosexual women do.
- * Using existing services such as the legal system or battered women's movement is tantamount to "coming out," which is a major life decision.
- * Lesbian and gay male support services themselves often minimize lesbian/gay domestic violence because service providers are ignorant of the severity of lesbian/gay battering, and because to acknowledge the abuse may destroy the myth of lesbian utopia or gay male enlightenment.
- * Lesbian and gay survivors may know few or no other gays; leaving the abuser could mean total isolation from their community.
- * The lesbian/gay community is small, and it is likely everyone the survivor knows will soon know of his/her abuse.
- * The batterer can use blackmail to hold the victim in the relationship. Being "outed" at work or to parents is sometimes more threatening than the abuse.
- * If there are children in the relationship, seeking help will mean the survivor may never see the children again since gays/lesbians have limited parental rights; if the children are the survivors, seeking help may mean separation from both parents.
- * Often, for gays/lesbians sympathetic friends are hard to find since the gay/lesbian community is not eager to acknowledge weaknesses which the heterosexual world will use to support its homophobic stereotypes.

DOMESTIC VIOLENCE

EFFECTS OF DOMESTIC VIOLENCE ON CHILDREN

Fact Sheets

EFFECTS OF DOMESTIC VIOLENCE ON CHILDREN

In homes where domestic violence occurs, children are at high risk of suffering physical abuse themselves. Regardless of whether children are physically abused, the emotional effects of witnessing domestic violence are very similar to the psychological trauma associated with being a victim of child abuse. Each year, an estimated minimum of 3.3 million children witness domestic violence.

- ◆ Children in homes where domestic violence occurs are physically abused or seriously neglected at a rate 1500% higher than the national average in the general population.
- ◆ Research results suggest that battering is the single most common factor among mothers of abused children.
- ◆ A major study of more than 900 children at battered women's shelters found that nearly 70% of the children were themselves victims of physical abuse or neglect. Nearly half of the children had been physically or sexually abused. Five percent had been hospitalized due to the abuse. However, only 20% had been identified and served by Child Protective Services prior to coming to the shelter. The same study found that: the male batterer most often abused the children; in about one-fourth of the cases, both parents abused the children; and in a few instances only the mother abused the children.
- ◆ Lenore Walker's 1984 study found that mothers were 8 times more likely to hurt their children when they were being battered than when they were safe from violence.
- ◆ Although child abuse and neglect are strongly linked to domestic violence, child protection organizations have paid little attention to the concurrence of the two problems. For example, in 1984, only 15 states participating in the American Humane Association's National Study of Child Abuse and Neglect collected data on the mother's abuse. In 1985, this number dropped to 6 states collecting these data.
- ◆ Children in homes where domestic violence occurs may "indirectly" receive injuries. They may be hurt when household items are thrown or weapons are used. Infants may be injured if being held by their mother when the batterer strikes out.
- ◆ Older children may be hurt while trying to protect their mother.
- ◆ Children from violent homes have higher risks of alcohol/drug abuse and juvenile delinquency.
- ◆ Approximately 90% of children are aware of the violence directed at their mother.
- ◆ Children are present in 41-55% of homes where police intervene in domestic violence calls.

Some of the emotional effects of domestic violence on children include:

- Taking responsibility for the abuse;
 - Constant anxiety (that another beating will occur);
 - Guilt for not being able to stop the abuse or for loving the abuser;
 - Fear of abandonment.
- ◆ Children in homes where domestic violence occurs may experience cognitive or language problems, developmental delay, stress-related physical ailments (such as headaches, ulcers, and rashes), and hearing and speech problems.
 - ◆ The majority of abused women who use shelter services bring their children. In one study, 72% of the women brought children to the shelter; 21% were accompanied by three or more children.
 - ◆ Boys who witness domestic violence are more likely to batter their female partners as adults than boys raised in nonviolent homes. There is no evidence, however, that girls who witness their mothers' abuse have a higher risk of being battered as adults.
 - ◆ Approximately 15 states have passed legislation recognizing that domestic violence should affect child custody decisions.

Information compiled from:

Carlson, B.E. "Children's Observations of Interpersonal Violence." In A.R. Roberts (ed) *Battered Women and Their Families Intervention Strategies and Treatment Programs*. New York Springer, 1984, 147-167.

"Children: The Forgotten Victims of Marital Violence." *Virginia Child Protection Newsletter*, Vol. 19. Spring 1986.

Gondolf, E. and Fisher, E. *Battered Women As Survivors: An Alternative to Treating Learned Helplessness*. Lexington, MA: Lexington Books, 1988.

Hotaling, G.T. and Sugarman, D.B. "An Analysis of Risk Markers in Husband to Wife Violence: The Current State of Knowledge." *Violence and Victims* 1(2):1986, 101-124.

Layzer, Goodson, and deLange, "Children in Shelters," *Children Today*, March-April 1986.

Stacy, W.A. and Shuse, A. *The Family Secret: Domestic Violence in America*. Boston: Beacon Press, 1983.

Starx E., and Fliterart, A. "Woman-Battering, Child Abuse and Social Heredity: What is the Relationship?" in Johnson (ed), *Marital Violence*, Sociological Review Monogram #31, London: Routledge & Kegan Paul, 1985.

Walker, L. *The Battered Woman Syndrome*, New York: Sonnger, 1984.

SOURCE:

NATIONAL WOMAN ABUSE PREVENTION PROJECT

ELDER ABUSE

Alaska Statute 47.24.010 mandates that EMS personnel report suspicions that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect, or self-neglect. The report must be made within 24 hours after first having cause for the belief. The number for submitting reports is 1-800-478-9996 and, in Anchorage, 269-3666.

The following indicators, by themselves, do not necessarily signify abuse or neglect. They may be clues, however, and thus helpful in assessment of abuse or neglect.

Possible Indicators of Physical Abuse

- Frequent injuries such as bruises, cuts, black eyes, or burns;
- Any injury incompatible with history;
- Any injury which has not been properly cared for (injuries are sometimes hidden on areas of the body normally covered by clothing);
- Poor skin condition or poor skin hygiene;
- Absence of hair and/or hemorrhaging below scalp;
- Lack or reaction to pain.

Possible Indicators of Psychological/Emotional Abuse

- Helplessness;
- Hesitation to talk openly;
- Implausible stories;
- Confusion or disorientation;
- Anger;
- Fear;
- Withdrawal;
- Depression;
- Denial;
- Agitation.

Possible indicators of Financial Abuse

- Unusual or inappropriate activity in bank accounts;
- Signatures on checks, etc., that do not resemble the older person's signature, or signed when older person cannot write;
- Power of attorney given, or recent changes or creation of will, when the person is incapable of making such decisions;
- Unusual concern by caregiver that an excessive amount of money is being expended on the care of the older person;
- Numerous unpaid bills, overdue rent, when someone is supposed to be paying the bills for a dependent elder;

- Lack of amenities, such as TV, personal grooming items, appropriate clothing, that the estate can well afford;
- Missing personal belongings such as art, silverware, or jewelry;
- Deliberate isolation, by a housekeeper, of an older adult from friends and family, resulting in the caregiver alone having total control.

Possible Indicators of Neglect by Caregiver

- Dirt, fecal/urine smell, or other health and safety hazards in elder's living environment;
- Rashes, sores, lice on elder;
- Obvious malnutrition;
- Habitually dressed in torn or dirty clothes;
- Obvious fatigue and listlessness;
- Begs for food;
- In need of medical or dental care;
- Left unattended for long periods of time.

Possible Indicators of Sexual Abuse

- Physical signs of sexually transmitted diseases;
- Evidence of injury to the genital area;
- Difficulty in sitting or walking;
- Fear of being alone with caretakers.

Possible Indicators of Abuse from the Caregiver

- The elder may not be given the opportunity to speak for him or herself, or see others, without the presence of the caregiver (suspected abuser);
- Attitudes of indifference or anger toward the dependent person, or the obvious absence of assistance;
- Family member or caregiver blames the elder (e.g. accusation that incontinence is a deliberate act);
- Aggressive behavior (threats, insults, harassment) by caregiver toward the elder
- Inappropriate display of affection by the caregiver;
- Flirtations, coyness, etc as possible indicators of inappropriate sexual relationship;
- Conflicting accounts of incidents by family, supporters, or victim;
- Inappropriate or unwarranted defensiveness by caregiver.

ALASKA DOMESTIC VIOLENCE DEFINITIONS AND STATUTORY CITATIONS

This section reviews applicable statutory laws and definitions related to domestic violence. The purpose is to familiarize EMTs with the terms and laws used by law enforcement officers with charges of domestic violence.

Definitions:

Domestic violence and crime involving domestic violence mean offense or attempt to commit the offense, by a household member against another household member. These include: a crime against the person, burglary, criminal trespass, arson or criminally negligent burning, criminal mischief, violating a domestic violence order and harassment. (AS 18.66.990)

Crisis intervention and prevention program means a community program that provides information, education, counseling, and referral services to individuals experiencing personal crisis related to domestic violence or sexual assault and to individuals in personal or professional transition excluding correctional half-way houses, outpatient mental health programs, and drug or alcohol rehabilitation programs. (AS 18.66.990)

Domestic violence program means a program that provides services to the victims of domestic violence, their families, or perpetrators of domestic violence. (AS 18.66.990)

Sexual assault program means a program that provides services to the victims of sexual assault their families, or perpetrators of sexual assault. (AS 18.66.990)

Lethality assessment means determination of the degree of danger of serious injury or death to any member of a client's family unit. (AS 13 AAC 90.190)

Stalking means engaging in a course of conduct that recklessly places another person in fear of death or physical injury, or in fear of the death or physical injury of a family member. (AS 11.41.260)

Nonconsensual contact means any contact with another person that is initiated or continues without that person's consent. The law broadly outlines types of activities that might fall into the course of conduct, including:

- following, approaching, confronting, or appearing within sight of a person;
- appearing at the residence or work place, or entering on property occupied by the victim, placing objects on or near property, etc.;
- contact through mail, telephone, or electronic communication.

Protective Orders. A person who is a victim of a crime involving domestic violence may file a petition under AS 18.66.100 for a protective order against a household

member. This order may prohibit the respondent from threatening to commit or committing domestic violence, stalking, or harassment and from making any direct or indirect contact with the petitioner. Other protections include:

- remove and exclude the respondent from the residence of the petitioner, regardless of ownership of the residence;
- direct the respondent to stay away from the residence, school, or place of employment of the petitioner or any specified place frequented by the petitioner or any designated household member;
- prohibit the respondent from entering a propelled vehicle in the possession of or occupied by the petitioner;
- prohibit the respondent from using or possessing a deadly weapon if the court finds the respondent was in the actual possession of or used a weapon during the commission of domestic violence;
- direct the respondent to surrender any firearm owned or possessed by the respondent if the court finds that the respondent was in the actual possession of or used a firearm during the commission of the domestic violence;
- request a peace officer to accompany the petitioner to the petitioner's residence to ensure that the petitioner
 - safely obtains possession of the petitioner's residence, vehicle, or personal items; and
 - is able to safely remove a vehicle or personal items from the petitioner's residence;
- award temporary custody of a minor child to the petitioner and may arrange for visitation with a minor child if the safety of the child and the petitioner can be protected; if visitation is allowed, the court may order visitation under the conditions provided in AS 25.20.061;
- give the petitioner possession and use of a vehicle and other essential personal item, regardless of ownership of the items;
- prohibit the respondent from consuming controlled substances;
- require the respondent to pay support for the petitioner or a minor child in the care of the petitioner if there is an independent legal obligation of the respondent to support the petitioner or child;
- require the respondent to reimburse the petitioner or other person for expenses associated with the domestic violence, including medical expenses, counseling, shelter, and repair or replacement of damaged property;
- require the respondent to pay costs and fees incurred by the petitioner in bringing the action under this chapter;
- order the respondent, at the respondent's expense, to participate in: (A) a program for rehabilitation of perpetrators of domestic violence that meets the standards set by the Department of Corrections under AS 44.28.020(b); or (B) treatment for the abuse of alcohol or controlled substances, or both;
- order other relief the court determines necessary to protect the petitioner or any household member.

Violation of this order may be a misdemeanor, punishable by up to one year of incarceration and up to a \$5,000 fine.

A court, through a peace officer, can grant emergency protective orders, if the court believes the victim is in immediate danger of domestic violence. This order expires 72 hours after it is issued unless dissolved earlier by the court at the request of the petitioner.

Statutes:

Alaska Statutes 47.17.010 requires EMS personnel who, in the performance of their professional duties, have reasonable cause to suspect that a child has suffered harm as a result of abuse or neglect must immediately (as soon as possible, no later than 24 hours) report that information to the nearest office of the state's Department of Health & Social Services, Division of Family & Youth Services (DFYS). The number for submitting reports is 1-800-478-4444. (See Alaska EMS website for complete information at http://www.hss.state.ak.us/dph/ems/ems_home.htm.)

Alaska Statutes 18.66.310 requires employers of state or local public employees, in consultation with the Council of Domestic Violence and Sexual Assault, provide continuing education in domestic violence for the public employees who are required by law to report abuse or neglect of children under AS 47.17.020.

Violent Crimes Compensation Board. AS 18.67.010 - 020. A board appointed by the governor for the purpose of facilitating and permitting the payment of compensation to innocent persons injured, to dependents of persons killed, and to certain other persons who by virtue of their relationship to the victim of a crime incur actual and reasonable expense. Claim applications are available from most police departments, District Attorney offices, and directly from the Violent Crimes Compensation Board. The board decides claims on a case-by-case basis. The Board's number is (907)465-3040.

Alaska Statutes 47.24.010 is similar to AS 47.17.010, except that it relates to abuse of persons 18 years of age or older who, because of physical or mental impairment, are unable to meet their own needs or to seek help without assistance. Under this statute, EMS personnel are required to report suspicions that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect, or self neglect. The report must be made within 24 hours after first having cause for the belief. The number for submitting reports is 1-800-478-9996 and, in Anchorage, 269-3666.

EMS RESPONSE TO DOMESTIC VIOLENCE

LAW ENFORCEMENT'S PERSPECTIVE

EMS may be only one part of a team to respond to a domestic violence scene. When EMS responds to a call where domestic violence is suspected, the following points can help the efforts of law enforcement:

1. Domestic violence is a crime. You are responding to a crime scene.
2. Every service provider on scene has the potential to inadvertently remove or destroy evidence. Encourage all providers to approach the scene through a single entry and use one pathway as a way to limit the contamination of the scene.
3. Do not contaminate or remove evidence. If the patient has torn or bloodied clothing that you must cut to get to injuries, leave the clothing or inform law enforcement of your findings.
4. If injuries are found during assessment that might not have been initially visible, inform law enforcement.
5. Communicate your treatment of injuries to law enforcement officers.
6. If patient needs to be transported immediately, leave your name and telephone number with the officers on duty in case they need additional information from you later.
7. Be aware of your demeanor. This may be the hundredth domestic violence call you've responded to; however, it may be the first for the victim.
8. Be aware of what you say. Law enforcement often carry tape recorders that can be used as evidence. What you say is part of the evidence.
9. Reinforce the victim's abilities to access resources and help.

DOMESTIC VIOLENCE AND SEXUAL ASSAULT PROGRAMS

COMMUNITY/PROGRAM

SERVICES PROVIDED

ANCHORAGE

Abused Women's Aid in Crisis (AWAIC)
100 West 13th Ave.
Anchorage, AK 99501
Phone: (907) 279-9581
Fax: (907) 279-7244
Crisis line: (907) 272-0100

Domestic violence: shelter, crisis line, advocacy, counseling, children's services, batterers' counseling, elder abuse services, prevention/education

Alaska Women's Resource Center (AWRC)
111 W. 9th Ave.
Anchorage, AK 99501
Phone: (907) 279-6316
Fax: (907) 276-6754
Crisis line: 489-3625

Domestic violence: crisis intervention, advocacy, counseling, prevention/education

Standing Together Against Rape (STAR)
1057 W Fireweed, Suite 230
Anchorage, AK 99503
Phone: (907) 276-7279
Fax: (907) 278-9983
Crisis line: 1-800-478-8999 or 276-7273

Sexual assault: crisis line, advocacy, counseling, children's services, elder abuse services, prevention/education

Victims for Justice (VFJ)
619 East Fifth
Anchorage, AK 99501
Phone: (907) 278-0977
Fax: (907) 258-0740

Survivors of homicide victims and violent crime victims: crisis intervention, advocacy, education & support/counseling

BARROW

Arctic Women In Crisis (AWIC)
P. O. Box 69
Barrow, AK 99723
Phone: 852-0261
Fax: 852-0315
Crisis line: 1-800-478-0267

Domestic violence/sexual assault: shelter, crisis line, advocacy, counseling, children's program, rural outreach, prevention/education

COMMUNITY

BETHEL

Tundar Women's Coalition
P.O. Box 1537
Bethel, AK 99559
Phone: 543-3455
Fax: 543-3752
Crisis line: 1-800-478-7799

CORDOVA

Cordova Family Resource Center (CFRC)
P.O. Box 863
Cordova, AK 99574
Phone: (907)424-5674
Fax: (907)424-5673
Crisis line: (907)424-4357

DILLINGHAM

Safe And Fear-Free Environment (SAFE)
P.O. Box 94
Dillingham, AK 99576
Phone: (907)842-2320
Fax: (907)842-2198
Crisis line: 1-800-478-2316 or (907)424-4357

EMMONAK

Emmonak Women's Shelter (EWS)
P.O. Box 207
Emmonak, AK 99581
Phone: (907) 949-1443
Fax: (907) 949-1718
Crisis line: 1-800-948-1434 or (907)949-1434

FAIRBANKS

Women In Crisis-Counseling & Assistance
(WIC-CA)
717 9th Ave.
Fairbanks, AK 99701
Phone: (907)452-2293
Fax: (907)452-2613
Crisis line: 1-800-478-7273
Crisis line: 1-800-478-7273

SERVICES PROVIDED

Domestic violence/sexual assault:
shelter, crisis line, counseling,
children's services, rural outreach,
prevention/education, client
advocacy

Domestic violence/sexual assault:
safe homes, crisis line, counseling,
advocacy, prevention/education

Domestic violence/sexual assault:
shelter, crisis line, counseling,
children's program, rural outreach,
prevention/education

Domestic violence/sexual assault:
shelter, crisis intervention

Domestic violence/sexual assault:
shelter, crisis line, advocacy
counseling, children's services,
elder abuse services, rural outreach,
prevention/education

COMMUNITY/PROGRAM**SERVICES PROVIDED****HOMER**

South Peninsula Women's Services (SPWS)
3776 Lake Street, Suite 100
Homer, AK 99603
Phone: (907)235-7713
Fax: (907) 235-2733
Crisis line: 1-800-478-7712 or 235-8101

Domestic violence/sexual assault:
safe homes, crisis line, advocacy,
children's program, counseling,
rural outreach, prevention/education

JUNEAU

Aiding Women from Abuse and Rape
Emergencies (AWARE)
P.O. Box 020809
Juneau, AK 99802-0809
Phone: (907)586-6623
Fax: (907) 586-2479
Crisis line: 1-800-478-1090 or 586-1090

Domestic violence/sexual assault;
Shelter, crisis line, advocacy,
counseling, children's services,
elder abuse services, rural outreach,
prevention/education

Tongass Community Counseling Center
(TCCC)
222 Seward Street, Suite 202
Juneau, AK 99801
Phone: (907)586-3585
Fax: (907)586-3241

Domestic violence: batterers'
counseling, children's services,
prevention/education

KENAI/SOLDOTNA

Kenai/Soldotna Women's Resource and Crisis
Center (K/SWRCC)
325 Spruce Street
Kenai, AK 99611
Phone: (907)283-9479
Fax: (907)283-5844
Crisis line: (907)283-7257

Domestic violence/sexual assault:
shelter, crisis line, advocacy, elder
abuse, counseling, children's
programs, prevention/education

KETCHIKAN

Women In Safe Homes (WISH)
P.O. Box 6552
Ketchikan, AK 99901
Phone: (907) 225-0202
Fax: (907)225-2472
Crisis line: 1-800-478-9474 or (907)225-9474

Domestic violence/sexual assault:
shelter, crisis line, advocacy,
counseling, children's services, rural
outreach, prevention/education

COMMUNITY/PROGRAM

KODIAK

Kodiak Women's Resource and Crisis Center
(KWRCC)
P.O. Box 2122
Kodiak, AK 99615
Phone: (907)486-6171
Fax: (907)486-4264
Crisis line: (907)486-3625

NOME

Bering Sea Women's Group (BSWG)
P.O. Box 1596
Nome, AK 99762
Phone: (907)443-5491
Fax: (907)443-3748
Crisis line: 1-800-570-5444 or (907)443-5444

PALMER

Valley Women's Resource Center (VWRC)
403 South Alaska Street
Palmer, AK 99645
Phone: (907)746-4080
Fax: (907)746-1177
Crisis line: 1-800-478-4090

SEWARD

Seward Life Action Council (SLAC)
P.O. Box 1045
Seward, AK 99664
Phone: (907)224-5257
Fax: (907)224-7081
Crisis line: (907)224-3027

SITKA

Sitkans Against Family Violence (SAFV)
P.O. Box 6136
Sitka, AK 99835
Phone: (907)747-3370
Fax: (907)747-3450
Crisis line: 1-800-478-6511

SERVICES PROVIDED

Domestic violence/sexual assault:
shelter, crisis line, advocacy,
counseling, children's services, rural
outreach, prevention/education

Domestic violence/sexual assault:
shelter, crisis line, advocacy,
counseling, children's services, rural
outreach, prevention/education

Domestic violence/sexual assault:
shelter, crisis line, advocacy,
counseling, children's services,
prevention/education

Domestic violence/sexual assault:
safe homes, crisis line, advocacy,
counseling

Domestic violence/sexual assault:
shelter, crisis line, advocacy,
counseling, children's services, rural
outreach, prevention/education

COMMUNITY/PROGRAM**SERVICES PROVIDED****UNALASKA**

Unalaskans Against Sexual Assault and
Family Violence (USAFV)
P.O. Box 36
Unalaska, AK 99685
Phone: (907)581-1500
Fax: (907)581-4568
Crisis line: 1-800-478-7238

Domestic violence/sexual assault:
shelter, crisis line, counseling,
advocacy, prevention/education

VALDEZ

Advocates for Victims of Violence (AVV)
P.O. Box 524
Valdez, AK 99686
Phone: (907)835-2980
Fax: (907)835-2981
Crisis line: 1-800-835-4044 or (907)835-2999

Domestic violence/sexual assault:
shelter, counseling, crisis line, client
advocacy, children's services,
prevention/education, rural outreach



ALASKA FAMILY VIOLENCE PREVENTION PROJECT (AFVPP)

Section of Maternal, Child, and Family Health
1231 Gambell St.
Anchorage, AK 99501
(907) 269-3454 / fax (907) 269-3432
(800) 799-7570 (toll free within Alaska)

AFVPP Clearinghouse

The Alaska Family Violence Prevention Project provides technical assistance and training referrals on domestic violence for health care and service providers. The AFVPP Clearinghouse provides central, statewide access to family violence educational/training resources.

TO ORDER or obtain MORE INFORMATION:

Call, fax, or write to us to--

- request items below (using the attached order form),
- check on new arrivals not on this listing,
- ask for more information re. the content of an item, and/or
- request assistance with a search for related information.
(List updated 10-13-98.)

A block around a title indicates that the item is new.

DV Posters, Training Overheads & Slides, Magnets, Buttons:

*In stock and available to you at no charge for your local training, display, distribution--
A variety of Posters, "One in five" booklet, "RADAR" magnets, buttons. DV slide/overhead training
curriculum sets are available to AFVPP "Train the Trainers."*

*(In addition, other videos and booklets are available from the Section of Maternal, Child, and Family Health
on pregnancy, accidents, alcohol, abstinence, babies and baby care, nutrition, and a variety of other
women's issues.)*

*Just ask! If you have items you'd like to see added to this list, we appreciate your
suggestions/feedback.*

If you have suggestions for resources you would like to see added to the AFVPP Clearinghouse, or need assistance locating other family violence resources/training materials, let us know.

Children and Child Abuse (see also Teen & Guidelines...)-

DV-BKT- "Anoka County Prenatal Abuse Project. Final Program Eval. Report," Loch
& Owen, Feb. 1996, Wilder Research Center, St. Paul, MN.

DV-V34	"BJ Learns About Federal & Tribal Court," for Native American children required to testify in court, 10 min. video, Produced by US Attorney's Office, District of Arizona, 4/92.
DV-BKT-A04	"Burn Injuries in Child Abuse," May 1997, US Dept. of Justice.
DV-V24	"Child Abuse," 22 min. video, Family Viol. in America: Power Within series, 1995, Altschul, 2 copies.
DV-A08	"1993 CH Responding to Maltreatment Conference," "Child Abuse and Intervention: The Role of Public Health Nurses," Benumof, Collins, Fox, Potter.
DV-BKT-	"Child Abuse Prevention Project--Final Report," 1995, Assoc. of State & Territorial Dental Directors, includes slides.
DV-BKT-A85	"Child Abuse and Neglect: A Look at the States, CWLA Stat Book," 1995, Curtis, Boyd, Liepold, Petit, Child Welfare League of America.
DV-BK-A07	<u>Child Abuse & Neglect: Cross-Cultural Perspectives</u> , edited by Jill E. Korbin, 1981, Paperback printing 1983, University of California Press, Berkeley, CA.
DV-BKT-A58	"Child Abuse Recognition and Reporting Manual," November 1996, compiled by Anne E. Zeiger, Safe and Fear-Free Environment, Dillingham, AK.
DV-BK-A08	<u>Child Abuse Reporting Legislation in the 1980s</u> , John E.B. Myers, JD, Wendell D. Peters, 1987, Amer. Assoc. for Protecting Children, Amer. Humane Assoc., Denver, CO.
DV-BKT	"Child Discipline: Guidelines for Parents," 1979, Gary May, National Committee to Prevent Child Abuse.
DV-BKT-	"Child Maltreatment: A Multidisciplinary Response," Child Maltreatment Conference manual, April 4-7, 1997, Homer, AK
DV-BKT-A47	"Child Sexual Exploitation: Improving Investigations and Protecting Victims, A Blueprint for Action," January 1995, U.S. Dept. of Justice.
DV-BK-	<u>Children and Adolescents with Disability Due to Traumatic Injury: A Data Book</u> , 1996, National Pediatric Trauma Registry.
DV-V04	"Children and Domestic Violence," 16 min., Domestic Violence: Broken Wings Series, 1994, Altschul Group Corp., Evanston, IL, 16 min., avail. in English & Spanish.
DV-BK-A10	<u>Children of Battered Women</u> , Peter G. Jaffe, David A. Wolfe, Susan Kaye Wilson, 1990, Vol. 21, Developmental Clinical Psychology & Psychiatry Series, Ed.: Alan A. Kazdin, Yale.
DV-V06	"Children of the Lie," Pennsylvania Bar Assoc., Pennsylvania Lawyers' Auxiliary, & PCADV.
DV-BK-A09	<u>Children and Violence</u> , September 1992, Report of the Twenty-Third Ross Roundtable on Critical Approaches, with Ambulatory Pediatric Assoc., Columbus, OH.

- DV-V05 **"The Children Are Watching,"** 1996, Altschul Group Corp., Evanston, IL, 12 min., avail. in English & Spanish.
- DV-BKT-A13 **"Children in the United States,"** March 1995, Children's Defense Fund.
- DV-BKT-A88 **"Consortium of Clearinghouses on Child Abuse and Neglect,"** booklet from Interagency Task Force on Child Abuse and Neglect, US Dept. of Health and Human Services.
- DV-BK-A11 **Conspiracy of Silence: The Trauma of Incest,** Sandra Butler, 1978, 1985, Volcano Press, Inc.
- DV-BKT-A46 **"Creative Healing Books"** Debra Whiting Alexander, PhD,. A Series of 10 creative booklets for healing post-traumatic stress, 1992/93, Bureau For At-Risk Youth
- DV-BKT-A48 **"Criminal Investigation of Child Sexual Abuse,"** May 1997, US Dept. of Justice.
- DV-BKT-A04 **"The Dental Coalition to Combat Child Abuse and Neglect,"** informational packet (slides), 1993, Medford, MA
- DV-BKT- **"The Dentist's Responsibility in Identifying & Reporting Child Abuse & Neglect,"** Third Ed., Dec. 1995, American Dental Assn. (2 copies).
- DV-BKT-A87 **"Domestic Violence: A National Curriculum for Children's Protective Services,"** (see Guidelines for Health Care Providers).
- DV-BKT-B01 **"Grassroots Prevention of Child Abuse and Neglect in Indian Communities: A Guide for the Community Organizer"** (See COMMUNITY COLLABORATION)
- DV-BKT-A59 **"Guidebook for the Visual Assessment of Physical Child Abuse,"** video and booklet, 1996, American Humane Association.
- DV-BKT-A49 **"Helping Children by Strengthening Families: A Look at Family Support Programs,"** Allen, Brown, Finlay, Feb. 1994, second printing, Children's Defense Fund.
- DV-BKT **Helping Kids Succeed--Alaskan Style,** July 1998, Assn. of Alaska School Boards and Section of Maternal, Child, and Family Health, DHSS, State of Alaska.
- DV-BKT- **"Injury Fatalities & Hospitalizations Among Massachusetts Children & Youth: 1985-1994,"** MA Dept. of Public Health, April 1997.
- DV-BKT-A50 **"Law Enforcement Response to Child Abuse,"** May 1997, US Dept. of Justice.
- DV-BKT- **"Linking a Response: Protocols for a Collaborate Approach to Child Abuse & Domestic Violence,"** June 1997, American Humane Association.

<p>DV-BKT series National Center for Missing & Exploited Children, 11 booklets: "Child Molesters: A Behavioral Analysis," Dec. 1992, 3rd ed.</p>
--

	<p>"Child Molesters Who Abduct: Summary of the Case in Point Series," March 1995</p> <p>"Child Sex Rings: A Behavioral Analysis," April 1992, 2nd ed.</p> <p>"Children Traumatized in Sex Rings," March 1988</p> <p>"Family Abduction: How to Prevent an Abduction and What to Do If Your Child Is Abducted," January 1994, 4th ed.</p> <p>"Female Juvenile Prostitution: Problem and Response," December 1992</p> <p>"For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions," June 1996, 4th ed.</p> <p>"An Analysis of Infant Abductions," March 1995</p> <p>"Missing and Abducted Children: A Law Enforcement Guide to Case Investigation and Program Management," September 1994</p> <p>"Recovery and Unification of Missing Children: A Team Approach," March 1995</p> <p>"Selected State Legislation: A Guide for Effective State Laws to Protect Children," May 1993, 3rd ed.</p>
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DV-BKT-A51 **"Prevent Abuse and Neglect through Dental Awareness,"** PANDA Coalition, 1992, packet.

DV-BK-A32 **Preventing Child Sexual Abuse: Sharing the Responsibility**, Sandy K. Wurtele & Cindy L. Miller-Perrin, 1992, University of Nebraska Press, Lincoln, NE.

DV-BKT-A86 **"Serious and Fatal Child and Adolescent Injuries in Alaska 1991-1994,"** October 1997, written & compiled by Martha Moore, MS, SOA Public Health, Community Health and Emergency Medical Services.

DV-BKT-A27 **"Sad Is How You Feel When Mom Is Being Beat,"** Illinois Coalition Against Domestic Violence, (currently out-of-stock).

DV-BKT-A70 **"Starting Points: Meeting the Needs of Our Youngest Children,"** Report of the Carnegie Task Force, April 1994, Carnegie Corporation of New York. (2 versions: Abridged Version and original report.)

DV-BKT-A52 **"State of America's Children Yearbook 1995,"** Children's Defense Fund.

DV-BKT-A53 **Understanding and Investigating Child Sexual Exploitation,** August 1997, US Dept. of Justice.

DV-BK	<p><u>Understanding the Medical Diagnosis of Child Maltreatment: A Guide for Non-Medical Professionals</u>, 1989, prepared by Smith, Benton, Moore, Runyan. American Humane Association.</p>
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DV-BKT- **"Violence & Its Impact on Young Children with Disabilities,"** June 1997, Pennsylvania Dept. of Health & NEC-TAS.

DV-BK-A03 **What Do You Know About Child Abuse**, Sanders & Myers, 1996, Copper Beech Books, Brookfield, CT.

DV-BK-A95 **What Jamie Saw**, Carolyn Coman, 1995, Front Street. Won Newbery Honor and National Book Award Finalist.

DV-BK-A50 **When Mommy Got Hurt: A Story for Young Children About Domestic Violence**, Ilene Lee and Kathy Sylwester, 1996, KIDSRIGHTS, Charlotte, NC.

- DV-V31 **"Young Once Indian Forever: Protecting the Children of Indian Country,"**
video, 1996, National Indian Justice Center, Inc., Petaluma, CA.

Community Collaboration and Team Building-

- DV-BK-A57 **Building Safe Communities: State and Local Strategies for Preventing Injury and Violence**, 1994, prepared by Children's Safety Network and Nat'l Ctr. for Education in Maternal & Child Health, Arlington, VA. (binder)
- DV-BK-A05 **Changing the Landscape: Ending Violence-Achieving Equality. 1993. Executive Summary/National Action Plan**, Canadian Panel on Violence Against Women.
- DV-BK-A06 **Changing the Landscape: Ending Violence-Achieving Equality. 1993. Final Report**, Canadian Panel on Violence Against Women.
- DV-BKT-A02 **"Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey,"** Michael Winer, Karen Ray, 1994, Amherst H. Wilder, St. Paul, MN (set).
- DV-BKT-A03 **"Collaboration: What Makes It Work. A Review of Research Literature on Factors Influencing Successful Collaboration,"** Paul W. Mattessich and Barbara R. Monsey, 1992, Amherst H. Wilder Foundation, St. Paul, MN (set).
- DV-BK-A59 **Developing Community Capacity**, module one, The HealthCare Forum, San Francisco, CA. (binder)
- DV-BK-A16 **Ending the Cycle of Violence: Community Responses to Children of Battered Women**, Einat Peled, Jeffrey L. Edleson, eds., 1995, Sage Publications, Thousand Oaks, CA.
- DV-BKT-B01 **"Grassroots Prevention of Child Abuse and Neglect in Indian Communities: A Guide for the Community Organizer,"** 1991, Northwest Indian Child Welfare Institute, Portland, OR.
- DV-BKT-A19 **"An Integrated Response to Wife Assault: A Community Model,"** Peter Jaffe and Carole Anne Buris, December 1981, London Family Court Clinic, Dept. of Psychology, Univ. of Western Ontario, London, Canada.

- DV-BKT-A22 **"A Model for Community Mobilization Against Domestic Violence,"** July 1995, includes Market Research Part I, Market Research Appendices, Market Research Part II, Project Factsheet, and Final Report, CSR, Inc.. funded by U.S. Maternal and Child Health Bureau.
- DV-BK-A97 **New Approaches to Evaluating Community Initiatives**, edited by James P. Connell, Anne C. Kubisch, Lisbeth B. Schorr, Carol H. Weiss, 1995, Aspen Institute.
- DV-IK-08 **"The Peer Support Program: A Women's Volunteer Program to End Violence Against Women--How To Kit,"** March 1995, Community Resource Centre of Goulbourn, Kanata and West Carleton, Ontario.

DV-BKT-	<u>Training for Transformation: A Handbook for Community Workers</u> , Anne Hope & Sally Timmel, revised 1995 edition, set of 3, Mambo Press, Gweru, Zimbabwe.
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- DV-BKT- **Vision & Action: Enhancing Community Efforts to Prevent Domestic Violence,** Maternal Child Health Bureau, Participants' Manual-Central Kenai Peninsula, Feb. 1997.

Domestic/Family Violence (general)-

- DV-BK-A02 **Aggression and Violence Throughout the Life Span**, Ray DeV. Peters, Robert J. McMahon, Vernon L. Quinsey, editors, 1992, Sage Publications, Newbury Park, CA.
- DV-V30 **"Battered Hearts: A Story of Family Violence,"** video.
- DV-BK-A04 **Battered Wives**, Del Martin, 1976, 1981, revised, updated, Volcano Press.
- DV-BK-A54 **The Battered Woman's Survival Guide: Breaking the Cycle**, 1995, Jan Berliner Statman, Taylor Publishing Co.
- DV-V23 **"Cancelled Lives: Letters from the Inside,"** 41 min. video, Bureau for At-Risk Youth.
- DV-V08 **"Crimes Against the Future,"** 23 min 43 sec., revised 8/30/89, March of Dimes, Birth Defects Foundation, National Office, White Plains, NY.
- DV-BK-A12 **The Counselor's Guide to Learning to Live Without Violence**, Daniel Jay Sonkin, PhD, 1995, Volcano Press, Volcano, CA.
- DV-BKT- **"Domestic Violence Advertising Campaign Tracking Survey, Post-Wave I, Nov. 1994-Feb. 1995, Appendix,"** Lieberman Research, Inc.
- DV-BKT-A41 **"Domestic Violence. Ignore it, and it will just go away..."** PCADV, booklet.
- DV-V14 **"Domestic Violence: Recognizing the Epidemic,"** 1992, Colorado Domestic Violence Coalition & Colorado Dept. of Health.
- DV-BKT-A11 **"Domestic Violence and Sexual Assault: Alaska's Status Report 1995,"** AK Council on Domestic Violence and Sexual Assault, AK Dept. of Public Safety, Juneau, AK.

DV-BKT-	"Domestic Violence and Sexual Assault: Alaska's Status Report 1996-1997," AK Council on Domestic Violence and Sexual Assault, AK Dept. of Public Safety, Juneau, AK.
DV-V15	"Escape the Abuse: Leaving Smart," distributed by: Intermedia, Inc., Seattle, WA, (videotape & instructional booklet).
DV-BK	<u>Family Violence</u> , 1989, edited by Lloyd Ohlin & Michael Tonry, Vol.11, Crime & Justice series, University of Chicago Press.
DV-BK-A64	<u>Family Violence Across the Lifespan: An Introduction</u> , Ola W. Barnett, Cindy L. Miller-Perrin, Robin D. Perrin, 1997, Sage Publications.
DV-BKT-A100	"Family Violence and the Clergy," developed by Texas Dept. of Human Services & Family Violence Advisory Committee. Printed with funds from Illinois Dept. of Public Aid.
DV-BK-A18	<u>Family Violence In Cross-Cultural Perspective</u> , David Levinson, 1989, Frontiers of Anthropology, vol. 1, Series ed., H.Russell Bernard, Sage Publications, Newbury Park,CA.
DV-BK-A52	<u>Future Interventions With Battered Women and Their Families</u> , Jeffrey L. Edleson & Zvi C. Eisikovits, eds., Sage series on Viol. Against Women, 1996, Sage Publications.
DV-V26	"Horror and the Healing," 22 min. video, Family Viol. in America, Power Within series, 1995, Altschul.
DV-V16	"Hostages At Home: A Video on Domestic Violence," 52 min. video and booklet, King-TV, Intermedia, Seattle, WA.
DV-A10	"Houses Divided," Domestic Violence Series, Minnesota Public Radio (MPR).
DV-BK-A51	<u>I Am Not Your Victim: Anatomy of Domestic Violence</u> , Beth Sipe, Evelyn J. Hall, SAGE series on Violence Against Women, 1996, Sage Publications.
DV-BK-A23	<u>Intimate Violence In Families</u> , Richard J. Gelles, Claire Pedrick Cornell, Second ed., 1990, Family Studies Text Series, Richard J. Gelles, ed., Sage Publications, Inc.
DV-BK-A24	<u>It Could Happen to Anyone: Why Battered Women Stay</u> , Ola W. Barnett & Alyce D. LaViolette, 1993, Sage.
DV-BKT	"Journey Beyond Abuse: A Step-by-Step Guide to Facilitate Women's Domestic Abuse Groups," 1997, Kay L. Fisher & Michael F. McGrane, Amherst H. Wilder Foundation, St. Paul, MN.
DV-V29	"Journey into Courage," Vermont Network Against DV & Sexual Assault, 57 min.
DV-BK-A25	<u>Keeping the Faith: Guidance for Christian Women Facing Abuse</u> , Marie M. Fortune, 1987, Harper, SanFrancisco, CA.
DV-BK-A27	<u>Leaving Abusive Partners: From the Scars of Survival to the Wisdom of Change</u> . Catherine Kirkwood, 1993, Sage Publications, Newbury Park, CA.

- DV-BK-A53 **Listening to the Thunder: Advocates Talk About the Battered Women's Movement**, Women's Research Centre, ed. by Leslie Timmins, Vancouver, British Columbia, 1995.
- DV-BKT-A21 **"Men Beating Women: Ending Domestic Violence: A Qualitative and Quantitative Study of Public Attitudes on Violence Against Women,"** April 1993, Prepared for Family Violence Prevention Fund, Prepared by EDK Associates, New York, NY.
- DV-BK-A68 **Naming the Violence: Speaking Out About Lesbian Battering**, Edited by Kerry Lobel, 1986, Seal Press.
- DV-Binder **"National Bulletin on Domestic Violence Prevention,"** monthly subscription, September 1996-current
- DV-BK-A55 **Next Time She'll Be Dead: Battering and How to Stop It**, Ann Jones, 1994, Beacon Press..
- DV-BKT-A40 **"No one deserves to be abused. Help for you or someone you care about,"** pamphlet by Education Programs Associates.
- Bookmarks AWAIC's , **"No One Deserves to Be Hit"** and **"Violence is not a cultural value"** bookmarks. Anchorage. (907) 272-0100
- DV-BK-A30 **Pattern Changing for Abused Women: An Educational Program**, Marilyn Shear Goodman, Beth Creager Fallon, 1995, Interpersonal Violence: The Practice Series (IVPS), Jon R. Conte, Series Editor, Sage Publications, Newbury Park, CA.
- DV-BK-A60 **Radical Feminist Therapy: Working in the Context of Violence**, Bonnie Burstow, 1992, Sage.
- DV-BK-A33 **Rape in Marriage**, Diana E.H. Russell, 1990, expanded & revised edition, Indiana University Press, Bloomington, IN.
- DV-BK-A36 **Sourcebook For Working With Battered Women**, Nancy Kilgore, 1992, Volcano Press, Volcano, CA.
- DV-BKT-A28 **"Standing Together Against Rape,"** STAR, 1057 West Fireweed, Ste. 230, Anchorage, AK 99503.
- DV-IK-07 **"Starting and Setting Up a Shelter Service for Battered Women,"** Connie Chaptman for Society of Transition Houses (BC/Yukon), 1994.
- DV-BK-A37 **Stopping Family Violence: Research Priorities for the Coming Decade**, David Finkelhor, 1988, Sage Publications, Newbury Park, CA.
- DV-BKT-A85 **"There's No Excuse for Abuse,"** resource kit, 1993, YWCA of Canada.
- DV-V20 **"To Find Our Way and First Steps,"** 32 min., AIMS Media., Chatsworth, CA.
- DV-BK-A38 **Transforming A Rape Culture**, edited by Emilie Buchwald, Pamela Fletcher, Martha Roth, 1993, Milkweed Editions, Minneapolis, MN.

- DV-BK-A99 **Trauma and Recovery: The aftermath of violence--from domestic abuse to political terror**, Judith Herman, MD, 1992/97, Basic Books, Harper Collins.
- DV-BK-A39 **Understanding and Preventing Violence, Biobehavioral Influences**, Volume 2, Albert J. Reiss, Jr., Klaus A. Miczek, Jeffrey A. Roth, editors, 1994, National Research Council, National Academy Press, Washington, DC.
- DV-BK-A40 **Understanding and Preventing Violence, Consequences and Control**, Volume 4, Albert J. Reiss, Jr., Klaus A. Miczek, Jeffrey A. Roth, editors, 1994.
- DV-BK-A56 **Understanding and Preventing Violence, Social Influences**, Volume 3, Reiss & Roth, editors, 1994.
- DV-BK-A61 **Understanding Violence Against Women**, Nancy A. Crowell and Ann W. Burgess, eds., 1996, National Research Council, National Academy Press, Washington, DC.
- DV-BK-A41 **Violence Against Women**, An International and Interdisciplinary Journal, Claire Renzetti, ed., June 1995, Sage Periodicals Press, Sage Publications, Inc., Thousand Oaks, CA.
Includes: volumes for June 1995 - February 1998
- DV-BK- **Violence and the Family**, 1996, Report of the Amer. Psychological Assn. Presidential Task Force on Violence & the Family, American Psychological Assn.
- DV-BK-A98 **Violence and Sexual Abuse at Home: Current Issues in Spousal Battering and Child Maltreatment**, Robert Geffner, PhD, Susan B. Sorenson, PhD, Paula K. Lundberg-Love, PhD, editors. 1997, Haworth Press.
- DV-BKT-A34 **"Violence Education: Toward a Solution,"** edited by Marybeth Hendricks-Matthews, April 1992, Society of Teachers of Family Medicine, Kansas City, MO.
- DV-BK-A67 **Violent Betrayal: Partner Abuse in Lesbian Relationships**, Claire M. Renzetti, 1992, Sage Publications.
- DV-BK-A45 **When Love Goes Wrong: What To Do When You Can't Do Anything Right: Strategies for women with controlling partners**, Ann Jones & Susan Schechter, 1992/93, Harper Perennial, HarperCollins Publishers, Inc.
- DV-BK-A70 **Wife Battering: A Systems Theory Approach**, Jean Giles-Sims, 1983, Guilford Press.
- DV-BK-A46 **Wife Rape: Understanding the Response of Survivors and Service Providers**, Raquel Kennedy Bergen, 1996, Sage Series on Violence Against Women, Sage Publications, Inc.
- DV-V21 **"Women and Domestic Violence,"** 16 min. video, Domestic Violence: Broken Wings Series, 1994, Altschul, avail. in English & Spanish.
- DV-BK-A58 **Women and Violence: Realities and Responses Worldwide**, Miranda Davies, Ed., 1994, Zed Books, Ltd., New Jersey.
- DV-BK-A47 **Women at Risk: Domestic Violence and Women's Health**, Evan Stark & Anne Flitcraft, 1996, Sage Publications, Inc., (2 copies).

Elder Abuse-

- DV-BKT- **“Abused Elders or Older Battered Women?”** AARP Forum Report, Oct.29-30, 1992.
- DV-BKT- **“Domestic Mistreatment of the Elderly,”** Richard L. Douglas, AARP, 1995.
- DV-BKT **“Elder Abuse & Neglect--Diagnostic & Treatment Guidelines,”** 11/92, American Medical Association.
- DV-BK-A66 **Gender Issues in Elder Abuse,** Lynda Aitken & Gabriele Griffin, 1996, Sage Publications.
- DV-BKT-A44 **“Older Battered Women: Integrating Aging and Domestic Violence Services,”** January 1996, National Center on Elder Abuse, Washington, DC.
- DV-BK-A49 **Rape and Older Women: A Guide to Prevention & Protection,** Nat’l Center for the Prevention & Control of Rape, Nat’l Inst. of Mental Health, US Dept. of Health, Education, & Welfare, 1979.

Guidelines and Protocols for Health Care Providers-

- DV-BK-A62 **Assessing and Treating Culturally Diverse Clients: A Practical Guide,** Freddy A. Paniagua, 1994, Sage.
- DV-BK- **Assessing Woman Battering in Mental Health Services,** 1998, Edward W. Gondolf, Sage Publications.
- DV-V01 **“The Battered Woman”** /Dr. Chez/Courtney Esposito, Counselors, Division on Women, State of New Jersey.
- DV-V02 **“The Battered Woman/ER.”**
- DV-A01 **“The Battered Women/MD.”**
- DV-V03 **“The Battered Woman/Mental Health Professional,”** Division on Women, State of New Jersey.
- DV-IK-01 **“Clinical Aspects of Domestic Violence for the Obstetrician Gynecologist,”** February 1993, American College of Obstetricians & Gynecologists (ACOG), Washington, DC, produced by PRACON 1800, Reston, VA. Includes booklet, video, directory of resources, sign, brochures, 2 sets.
- DV-BKT-A01 **“A Coordinated Approach to Reducing Family Violence: Conference Highlights,”** Research Report, Martha B. Witwer, Cheryl A. Crawford, October 1995, National Institute of Justice, American Medical Association, Rockville, MD.
- DV-BKT-A39 **“The Deadly Connection: Facts on Domestic Violence for Drug and Alcohol Counselors,”** PCADV brochure, Harrisburg, PA.
- DV-BKT-A89 **“Diagnostic Imaging and Child Abuse: Technologies, Practices, and Guidelines,”** Jenny, Taylor, Cooper, 1996, Medical Technology and Practice Patterns Institute.

DV-BKT-A05	"Diagnostic and Treatment Guidelines on Domestic Violence," 9/94, American Medical Association, Chicago, IL.
DV-BKT-A06	"Diagnostic and Treatment Guidelines on Mental Health Effects of Family Violence," 12/95, American Medical Association, Chicago, IL.
DV-BKT-A08	"Domestic Violence: A Directory of Protocols for Health Care Providers," 9/94, Children's Safety Network, Education Development Center, Inc. (EDC), Newton, MA.
DV-BKT	"Domestic Violence During Pregnancy," Prevention Resources, Saskatchewan Institute on Prevention of Handicaps.
DV-BKT-A09	"Domestic Violence: A Guide for Health Care Professionals," March 1990, third printing, Courtney N. Esposito, Domestic Violence Prevention Prog., Division on Women, State of New Jersey, Dept. of Community Affairs, Trenton, NJ.
DV-BK-A63	<u>Domestic Violence and Health Care: What Every Professional Needs to Know,</u> Sherri L. Schornstein, 1997, Sage, (2 copies).
DV-BKT-A10	"Domestic Violence Education: The American College of Nurse-Midwives Domestic Violence Education Module," Patricia A. Paluzzi and Charlotte Houde Quimby, first edition, 1995, Amer. Col. of Nurse-Midwives, Special Proj.Section, Washington, DC.
DV-BKT-A12	"Domestic Violence: Identifying and Treating Victims in the Emergency Room," September 1991, Seattle-King County, Dept. of Public Health, Human Services Roundtable, Quality Assurance, Seattle, WA, 2 copies.
DV-BKT-A87	<u>Domestic Violence: A National Curriculum for Children's Protective Services,</u> Susan Schechter and Anne L. Ganley, editor Janet Carter, 1996, Family Violence Prevention Fund, San Francisco, CA.
DV-BKT-A14	<u>Domestic Violence: A National Curriculum for Family Preservation, Practitioners,</u> Susan Schechter and Anne L. Ganley, editor Janet Carter, 1995, Family Violence Prevention Fund, San Francisco, CA.
DV-A11	"Domestic Violence Prevention Stalker," "Stairs" Public Service Announcement (PSA) from Family Violence Prevention Fund and The Advertising Council. 2 spots: 30 sec. & 60 sec.
packet	"Domestic Violence Protocol and Resource Handbook: A Primary Care Approach," Providence Health System Domestic Violence Project - Medallia Family Medical Center, revised January 1996, orig. May 1995, 2 sets.
packet	"DV 101' Introduction to Domestic Violence," Patti Bland, Providence Health System - Medallia HealthCare, agenda & packet, 11 dbl. pps, 2 sets.
DV-BKT-A14	"Family Violence: AAFP Home Study Self-Assessment," Jeffrey J. Patterson, DO, Monograph Edition 139, Home Study Self-Assessment program, Amer. Acad. of Family Physicians, Patterson, Jeffrey J., DO, Kansas City, MO, December 1990.

packet	“Family Violence: Partner Abuse/Domestic Violence. Information, Resources, & Referrals.” 1994, Violence is Preventable Campaign, AEMC Center for the Study of Violence, funding by Albert Einstein Society. Info. packet.
DV-BKT-	“Family Violence: Screening, Assessment, Intervention,” May 1996, Ramsey County Dept. of Public Health, Minnesota.
DV-BK-A21	<u>Groupwork With Children of Battered Women: A Practioner’s Manual</u> , Einat Peled and Diane Davis, 1995, Interpersonal Violence: The Practice Series (IVPS), Jon R. Conte, Series Editor, Sage Publications, Newbury Park, CA.
DV-BKT-A15	“Guidelines For Mental Health Practitioners In Domestic Violence Cases,” Susan Schechter, 1987, National Coalition Against Domestic Violence, Washington, DC.
DV-BKT	"Guidelines for the Screening of Persons Working with Chldren, the Elderly, & Individuals Working with Disabilities in Need of Support: Summary," April, 1998, Noy S. Davis, Project Director, et.al., US Dept. of Justice.
DV-BKT-A17	“Identifying and Treating Adult Victims of Domestic Violence,” January 1990, New York State Dept. of Health, with NY State Office for the Prevention of Domestic Violence, 2 copies.
DV-BKT-A18	“Identifying and Treating Battered Adult and Adolescent Women and Their Children: A Guide for Health Care Providers,” prepared by Emily Schiffrin and Candace Waldron, 1992, Women’s Health Unit, Division of Youth and Adult Health, Massachusetts Dept. of Public Health.
DV-BKT-A55	<u>“Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers,”</u> Warshaw & Ganley, 1995, Family Violence Prevention Fund, San Francisco, CA.
DV-BKT-A90	“Islands of Safety: Assessing and Treating Young Victims of Violence,” Joy D. Osofsky and Emily Fenichel, editors, 1996, Zero to Three, National Center for Infants, Toddlers and Families.
DV-BKT-	Linking A Response: Protocols for a Collaborative Approach to Child Abuse & Domestic Violence,” American Humane Association, 6/97.
DV-BKT-A98	“Living in a Violent Relationship,” set of booklet and video, 1996, Health Education Alliance.
packet	“Medical Domestic Violence Protocols and Standards,” 1/93, National Center on Women & Family Law, Inc., New York, NY.
DV-BKT-A20	“Medical Protocol--Adult Abuse, Neglect, and Exploitation: A Medical Protocol For Health Care Providers and Community Agencies,” Frederic J. Cowan, Attorney General, 1991, Commonwealth of Kentucky.
DV-BK-	<u>Medicolegal Death Investigator: A Systematic Training Program for the Professional Death Investigator</u> , 1996, Steven C. Clark, PhD, et.al., Occupational Research & Assessment.

packet	"New Hampshire, Statewide Conference on Family Violence," May 12-13, 1994, workshop descriptions.
DV-V100	"No Woman Deserves to be Hurt: Domestic Violence Education for Women's Health Care Providers," set of booklet and 2 videos, 1996, American College of Nurse-Midwives.
DV-BK-A29	<u>Nursing Care of Survivors of Family Violence</u> , Jacquelyn Campbell, RN, PhD, Janice Humphreys, RN,C,PhD, 2nd ed.,1993, Mosby-Year Book, Inc., St. Louis, MO.
DV-BKT-A23	"One in five women," 1987, Alaska Network on Domestic Violence and Sexual Assault, Juneau, AK.
DV-BK-A31	<u>The Physician's Guide To Domestic Violence: How to Ask the Right Questions and Recognize Abuse...another way to save a life</u> , Patricia R. Salber, MD, Ellen Taliaferro, MD, 1995, Volcano Press, Volcano, CA.
DV-BKT-A42	"Physician Guide to Media Violence," 1996, American Medical Association, Chicago, IL.
DV-BK-A96	<u>Primary Care Physicians' Screening Practices for Female Partner Abuse in Alaska</u> , Linda B. Chamberlain, PhD, 1997. PhD Thesis, Johns Hopkins University.
DV-BKT-A24	"Proceedings: Interpersonal Violence. The Many Faces of Abuse." Feb. 1994, Seattle, WA. U.S. Public Health Service, Region X Conf. for Health Care Professionals.
DV-BKT-A25	"Protocol of Care for the Battered Woman," June 1986, Prevention of Battering During Pregnancy, Texas Women's University, Houston, TX.
DV-BKT-A26	"Public Health Nursing Domestic Violence Protocol," December 1993, Oregon Public Health Assoc., Public Health Nursing Section, Washington State Public Health Assoc., Seattle-King County Dept. of Public Health, Seattle, WA.
DV-BKT-A43	"Reporting Child Abuse & Neglect in Alaska: Information for Medical and Health Personnel," State of Alaska, Dept. of Health and Social Services, Div. of Family and Youth Sevices, Juneau. 6/95.
DV-BKT-A94	"Save the Evidence: Save a Life! Sexual Assault: The Medical-Legal Exam," set of 2 videos and booklet, 1995, Health Education Alliance.
DV-IK-05	"Sexual Assault Response Team Certification Program: Sexual Assault Evidence Collection Kits," 10/96, Alaska State Crime Lab.
DV-IK-06	"Sexual Assault Response Team Certification Program," South Peninsula Hospital, October 17-21, 1996.
DV-BK-A35	<u>The Silent World of Doctor and Patient</u> , Jay Katz, MD, 1984, Free Press, NY, NY.
DV-BKT	"St. Joseph's Health Centre Woman Abuse Protocol," April 1996, St. Joseph's, Toronto.

DV-BK-A94	<u>Strategies for Confronting Domestic Violence: A Resource Manual</u> , 1993, United Nations Office at Vienna, Centre for Social Development and Humanitarian Affairs.
DV-BKT-A29	“Strategies for the Treatment and Prevention of Sexual Assault,” 12/95, American Medical Association, Chicago, IL.
DV-BKT-B02	“Strengthening the Emergency Response to Domestic Violence: A General Information Packet,” Family Violence Prevention Fund's Health Resource Ctr. on Domestic Viol., San Francisco, CA.
DV-BKT-A30	“Strengthening the Primary Care Response to Domestic Violence: A General Information Packet,” Family Violence Prevention Fund's Health Resource Ctr. on Domestic Viol., San Francisco, CA.
DV-BKT-A31	“Suggested Protocols For Victims of Spousal and Elder Abuse,” A Task Force Reference Document for Colorado Hospitals, July 1992, Prepared by Deborah Haack, Coord., Family Violence Prevention Prog., Injury Prevention and Control Prog., CO Dept. of Health, Denver, CO, 2 copies.
DV-BKT-A32	“Training Manual: Sexual Assault Response Team/Sexual Assault Nurse Examiner,” 1992, edited by Sherry Arndt, Coordinator, SART/SANE, Nurse Examiner Program, Dominican Hospital, Santa Cruz, CA.
DV-BKT-A33	“Trust Talk: Break the silence. Begin the cure.” March 1992, Ohio Physicians' Domestic Violence Prevention Project, sponsored by the Ohio State Medical Assoc./Ohio Dept. of Human Services, Columbus, OH.
DV-BKT-	“Violence Against Women in the US: A Comprehensive Background Paper,” March 1996, Commonwealth Fund Commission on Women's Health, Columbia Univ.
DV-BKT-B03	“Violence and Teen Pregnancy: A Resource Guide for MCH Practitioners,” May 1997, Anara Guard, Children's Safety Network, HRSA.
DV-A07	“What Health Care Providers Should Know About Family Violence,” 1993 National Perinatal Assoc., NPA-324, Teach'em, Chicago, IL.
DV-BKT-A35	“What You Can Do About Family Violence: A Federation Guide to The Physicians' Campaign Against Family Violence,” American Medical Assoc., Chicago, IL, 7/92.
DV-BKT-A36	“What Works in Preventing Rural Violence: Strategies, Risk Factors, and Assessment Tools,” Barbara Monsey, et al., 1995, Amherst H. Wilder Foundation, St. Paul, MN, (set).
DV-BKT-A37	“Why Does Daddy Hit Mommy? Break the Cycle of Family Violence!” “Domestic Violence: A Course in Assessment & Intervention (Course II),” 1993, Health Education Alliance, developed in collaboration with NEXT DOOR, San Jose, CA.
DV-V33	“Working with the Battered Woman: A Guide for Counselors,” video, DV Prevention Prog., Div. on Women, NJ Dept. of Community Affairs.

Law and Legal-

- DV-BK-A01 **Abused and Battered: Social and Legal Responses to Family Violence**, Dean D. Knudsen & JoAnn L. Miller, eds., 1991, Social Institutions & Social Change series, Michael Useem & James D. Wright, series eds., Aldine de Gruyer, Hawthorne, NY.
- DV-V32 **"Bitter Earth: Child Sexual Abuse in Indian Country,"** 45 min. video, Office for Victims of Crime, Federal Crime Victims Div., US Dept. of Justice.
- DV-V10 **"Domestic Violence and Law Enforcement,"** 30 min. video, 1992, by University of Alaska, Justice Center, 2 tapes.
- DV-BK-A15 **Domestic Violence on Trial: Psychological and Legal Dimensions of Family Violence**, Daniel Jay Sonkin, PhD, Editor, 1987, Springer Publishing Co., NY, 2 copies.
- DV-BKT-A56 **"Family Law Quarterly: Special Issue on Domestic Violence,"** Summer 1995, American Bar Assoc., Section of Law.
- DV-BK-A72 **The Female Offender: Girls, Women, and Crime**, 1997, Meda Chesney-Lind, Women and the Criminal Justice System series, Sage Publications.
- DV-BK-A19 **The Forgotten Child In Health Care: Children in the Juvenile Justice System**, Linda S. Thompson, editor, 1991, National Center for Education in the Maternal and Child Health (NCEMCH), Washington, DC.
- DV-BKT-A38 **"A Guide to Alaska's Criminal Justice System,"** Marsha Vandercook, Alaska Judicial Council, March 1996.
- DV-BKT-A16 **"A Handbook for Victims of Crime in Alaska,"** Alaska Judicial Council, Marcia Vandercook, January 1995.
- DV-BKT-A61 **"Instant Evidence,"** Winter 1996 and Spring 1997 issues, Polaroid Corporation, Journal for Law Enforcement Issues.
- DV-V101 **"Journey to Safety: Assembling the Pieces,"** Alaska Network on Domestic Violence and Sexual Assault, Legal Advocacy Project, video-24:14 min., in English, Yup'ik, or Spanish.
- DV-V18 **"Patient to Plaintiff, Plenary Session of the National Conference on Family Violence: Health and Justice,"** 1 hr.33 min. video, March 11-13, 1994, American Medical Association.
- DV-BK-A22 **"Providing Legal Protection for Battered Women: An Analysis of State Statutes and Case Law," HOFSTRA Law Review**, Catherine F. Klein & Leslye E. Orloff, Summer 1993, Volume 21, No. 4, School of Law, Hofstra University.
- DV-BKT-A45 **"The Quincy Court: Model Domestic Abuse Program,"** 1994. Set includes: "Manual," "Who Are the Victims. What Must Courts Do To Protect Them?," and 20 min. video "Spousal/Partner Assault: A protocol for the sentencing and supervision of offenders." Lerner & Chatterjee, Production Specialties, 2 copies.

- DV-BK- **Rural Women Battering & the Justice System: An Ethnography**, 1998, Neil Websdale, Sage Series on Violence Against Women.
- DV-BKT- **“Victim Costs & Consequences: A New Look,”** February 1996, Miller, Cohen, Wiersema, Nat’l Institute of Justice.

Men and Domestic Violence-

- DV-BK-A75 **Broken By You: Men’s Role in Stopping Woman Abuse**,” Morton Patterson, 1995, United Church Publishing House, Ontario, Canada.
- DV-BK-B01 **Foundations for Violence-Free Living: A Step-by-Step Guide to Facilitating Men’s Domestic Abuse Groups**, 1995, David J. Mathews, Amherst H. Wilder Foundation.
- DV-BK-A26 **Learning To Live Without Violence: A Handbook for Men**, Daniel Jay Sonkin and Michael Durphy, 1989, Volcano Press, Volcano, CA.
- DV-A02 **“Learning to Live Without Violence: A Worktape for Men,”** Audio. Adapted from the book by Daniel Jay Sonkin, PhD and Michael Durphy, MD. Narrated by Adam Gottstein. 2 copies.
- DV-BK-A28 **The Male Batterer: A Treatment Approach**, Daniel Jay Sonkin, PhD, Del Martin, Lenore E.A. Walker, EdD, 1985, Springer Series: Focus on Men, James Hennessy, PhD, Series Editor, Springer Publishing, New York.
- DV-V17 **“Men and Domestic Violence,”** 19 min. video, Domestic Violence: Broken Wings Series, 1994, Altschul, available in English and Spanish.
- DV-BK-B02 **On the Level: Foundations for Violence-Free Living**, 1995, David J. Mathews, Amherst H. Wilder Foundation.
- DV-BK-A44 **Violence No More: Helping Men End Domestic Violence**, Michael Paymar, Training Coordinator, Duluth Domestic Abuse Intervention Project, 1993, Hunter House, Inc. Publishers, Alameda, CA.

Other-

- DV-BK-B03 **Alkali Lake. Sharing, Caring, and Consequences: A Study of Sobriety and Healing at Alkali Lake Reserve**, 1993, A Quantitative and Social Policy Research Study, British Columbia, Canada.
- DV-V102 **Alkali Lake. "The Honour of All."** 3 videos--26 min, 43 min, 57 min., Alkali Lake Indian Band, British Columbia, Canada.
- DV-BK- **Case Study Research: Design & Methods**, 1989, Robert K. Yin, Sage Publications.
- DV-BK-A13 **Determinants of Pediatricians' Firearm Injury Prevention Counseling Practices**, Daniel W. Webster, December 1990, Doctoral Dissertation, Dept. of Health Policy & Management, Johns Hopkins Univ., School of Hygiene and Public Health.
- DV-BK-A20 **Gender, Family, and Economy: The Triple Overlap**, Rae Lesser Blumberg, editor, 1991, Sage Focus Edition, Sage Publications, Newbury Park, CA.
- DV-BK-A14 **Healing the Hate: A National Bias Crime Prevention Curriculum for Middle Schools**, McLaughlin & Brilliant, Jan. 1997, Education Development Center.
- DV-BK-A65 **Improving Intercultural Interactions: Modules for Cross-Cultural Training Programs**, Richard W. Brislin and Tomoko Yoshida, eds., 1994, Sage.
- DV-BK-B04 **Injury Fact Book**
- DV-BKT-A60 **National Network of Violence Prevention Practitioners**, binder set of booklets, 1997.
- DV-BK-A76 **Pathways to Peace: Forty Steps to a Less Violent America**, Victor LaCerva, MD, 1996, Heartsongs Publication.
- DV-BK-A34 **Raven's Children: An Alaskan Culture At Twilight**, Richard Adams Carey, 1992, Houghton Mifflin Company, New York, NY.
- DV-A09 **"STOP Steps to Prevent Firearm Injury,"** Center to Prevent Handgun Violence, American Academy of Pediatrics, 1994.
- DV-BKT-A91 **"Violence and Abuse Abstracts: Current Literature in Interpersonal Violence,"** issues including/up to April 1998, Sage.
- DV-BKT-A81 **"Project VIP: Violence is Preventable,"** Level 1 booklets, 1995, Bureau for At-Risk Youth.
- DV-V27 **"Violence Prevention: Inside Out,"** United Learning, with resource book, 62 min.

Substance Abuse-

DV-V11 **"Domestic Violence and Substance Abuse,"** 23 min. video, Domestic Violence: Broken Wings Series, 1994, avail. in English and Spanish.

DV-BKT	"An Analysis of National Data on the Prevalence of Alcohol Involvement in Crime," April 5-7, 1998, Lawrence Greenfield, US Dept. of Justice, 40 pps.
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Teen/Dating Violence (see also Children)-

DV-V28 **"Anger, Temper Tantrums, and Violent Emotions,"** 19 min. video, Guidance Club for Teens, Bureau for At-Risk Youth, 1993.

DV-V09 **"Date Rape: A Question of Trust,"** 23 min. video, 1995, Altschul Group, Evanston, IL, Produced by Pixie Bigelow Productions, Inc.

DV-BK-A71 **Dating Violence: Young Women in Danger**, edited by Barrie Levy, 1991, Seal Press.

DV-BKT-A07 **"Domestic/Dating Violence: An Information and Resource Handbook,"** December 1994, Prepared by Audrey Mitchell, Metropolitan King County Council, Report to the Public, Seattle, WA.

DV-V12 **"Domestic Violence and Young Adults,"** 23 min. video, Domestic Violence: Broken Wings Series, 1994, Altschul, avail. in English (2 copies) & Spanish.

DV-V30 **"How to Cope with School Violence,"** 20 min. video, Guidance Club for Teens, 1993, Bureau for At-Risk Youth.

DV-BK-A69 **In Love and In Danger: A Teen's Guide to Breaking Free of Abusive Relationships**, Barrie Levy, 1993, Seal Press.

DV-BKT- **"Just a Kiss: A Photo Novella about dating violence,"** 1993, Battered Women's Support Services, Vancouver, BC.

DV-V22 **"Partner Violence Among Young Adults,"** video, Terrie Moffitt, PhD, NIJ Research in Progress, July 1995.

DV-V25 **"Preventing Violence,"** 30 min. video, PeaceTalks with Michael Pritchard, Bureau for At-Risk Youth.

DV-BKT-A93 **"Taking Action to Prevent Adolescent Violence: Educational Resources for Schools and Community Organizations,"** June 1995, Children's Safety Network.

DV-BKT-A92 **"Teen Dating Violence Resource Manual,"** 1997, National Coalition Against Domestic Violence, booklet and slides. (see also TRAINING below.)

DV-BKT-B04 **"Teens: Pregnant and Battered: Training Module,"** 1996, Physicians for a Violence-Free Society, March of Dimes Birth Defects Found., & Kaiser Permanente Medical Care.

DV-BK-A100 **Treating Abused Adolescents**, Eliana Gil, 1996, Gilford Press, New York.

DV-BKT-B03 **"Violence and Teen Pregnancy: A Resource Guide for MCH Practitioners."** (See GUIDELINES and PROTOCOLS)

Training-

- packet **"Domestic Violence,"** 1995, NYS Office for the Prevention of Domestic Violence, Rensselaer, NY. 2 Info. packets.
- DV-V13 **"Domestic Violence Prevention," "Stairs"** Public Service Announcement (PSA), sponsored by the Family Violence Prevention Fund by The Advertising Council, 60 sec. & 30 sec. spots.
- packet **"DV Advanced Trainings: Cross-Cultural and Specific Populations,"** misc. listings, 5 pps, 2 sets.
- DV-BKT- **"Family Safety Advocates: Training Manual,"** Winter 1997, Earlene George, Safe & Fear-Free Environment.
- DV-BK-A48 **High-Impact Presentation and Training Skills....**, Dr. William Hendricks, Holliday, Mobley, Steinbrecher; National Press Publications, 1994.
- DV-IK-04 **"Powerful Presentation Skills,"** revised 6/92, Communication Series, National Seminars Group, Overland Park, Kansas, Div. of Rockhurst College, Continuing Ed. Center, Inc. Booklet, leaflet, test, 4 audio tapes.
 Tape 1. **"Powerful Presentation Skills: The Unspoken Message You Deliver & The Power of Voice Control."**
 Tape 2. **"Powerful Presentation Skills: Identify Your Style & Getting Started as a Presenter."**
 Tape 3. **"Powerful Presentation Skills: Presentation Tactics for Meetings."**
 Tape 4. **"Powerful Presentation Skills: Know Your Subject & Presenting Your Materials."**
- | | |
|------------|---|
| DV-BKT set | "Training for Transformation: A Handbook for Community Workers," revised edition 1995, reprinted 1996, 3 volumes, Anne Hope and Sally Timmel, Mambo Press, Zimbabwe. |
|------------|---|
- MAGNETS **"Have You Used Your 'RADAR' Today?"**, reminder to screen for domestic violence, AFVPP, reprinted with permission from Violence Is Preventable Campaign, AEMC Center for the Study of Violence, 1994.

OVERHEAD/SLIDES

- "Domestic Violence: The Role of the Physician in Identification, Intervention, and Prevention,"** A Slide Lecture Presentation, ACOG, Washington, DC, 1995.
- Domestic violence training curriculum slide and overhead sets--produced by AFVPP--**for "Train the Trainers" participants.
- "Physicians for a Violence Free Society"** - set of slides.
- "Teens: Pregnant and Battered: Training Module,"** 1996, Physicians for a Violence-Free Society, March of Dimes Birth Defects Found., & Kaiser Permanente Medical Care, booklet and slides.

POSTERS,etc. A selection of in-stock posters, "It's OK to talk to me..." buttons, "RADAR" screening magnets, and pamphlets are available.

DV in the Workplace-

DV-packet **"Work to End Domestic Violence,"** Organizer's Kit, Family Violence Prevention Fund, San Francisco,CA, 1998.



ALASKA FAMILY VIOLENCE PREVENTION PROJECT (AFVPP)

Section of Maternal, Child, and Family Health
1231 Gambell St.
Anchorage, AK 99501
(907) 269-3454 / fax (907) 269-3432
(800) 799-7570 (toll free within Alaska)

AFVPP Clearinghouse -Request Form-

If you would like more information on any of these items or if you would like to request them for review, complete the order form below. FAX, MAIL, or CALL in your order. A maximum of 10 items may be checked out each request.

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HITTING CLOSE TO HOME

Domestic Violence and the EMS Responder

By Frederick M. Schiavone, MD, FACEP, and Patricia R. Salber, MD, FACEP, FACP

An ambulance is called to a residence for an unconscious female. Outside the house, EMS personnel encounter a man, sitting on the hood of a pickup truck, yelling, “You’re gonna need a crane to move that horse!”

The EMS crew members enter the house, where they find a woman in her ninth month of pregnancy lying unconscious on the living room floor. Assessing the patient, the crew notes that blood is coming from a small laceration above her eye, which is surrounded by a large bruise. There is a long leg cast on her right leg and a bloody crutch lying next to her.

The crew also notes globs of coleslaw stuck to the walls of the living room and kitchen and a bottle of ketchup that apparently had been smashed against a wall.

The patient is examined further and no signs of active labor are noted. She is packaged with appropriate C-spine precautions and is prepared for transport to the nearest emergency department (ED).

As the crew members leave the house, they see the man still sitting on the hood of the pickup truck. This time he yells, “I hope she croaks.” They later learn this is the patient’s husband.

On arrival at the ED, crew members give an adequate patient history and physical report to the ED staff but they do not mention the environmental conditions they had witnessed at the home. Although this woman had a serious head injury inflicted in her ninth month of pregnancy, the EMS crew members failed to report a more serious and life-threatening problem. Their patient clearly was a victim of domestic violence.

AN ESTIMATED 3 MILLION TO 4 MILLION WOMEN in the United States are battered each year by their husbands or partners.¹ Approximately 50 percent of these women are beaten three or more times each year. And each year, between 2,000 and 4,000 of these women will be beaten to death. (While men are occasionally the victims of domestic violence, such cases constitute a small percentage. This article therefore will assume the victim is a woman. The issues of child abuse and elder abuse also will not be addressed at this time.)

Many women who are beaten will enter the medical system by either dialing or having someone else dial 9-1-1. Therefore, it is extremely important that prehospital providers become knowledgeable about and sensitive to the issues of domestic violence.

Most cases of domestic violence follow a typical pattern of abuse called the cycle of violence. This cycle consists of three main phases: the tension-building phase, the violent phase (usually preceded by an “unavailing trigger act”) and the honeymoon phase, during which the batterer is overtly remorseful for the violent act and is extremely solicitous of the victim.²

The cycle of violence recurs on a regular basis, often increasing in severity and frequency as time goes on. As long as this cycle perpetuates, the batterer controls the victim’s life. Recognizing that domestic violence is occurring and alerting others to that fact is the most important thing a health care provider can do to help the victim break the cycle of violence.

Battered women themselves often create barriers that prevent others from recognizing that they are victims of domestic violence. Some women are reluctant - for many reasons to disclose the true nature of their injuries. They may be embarrassed or ashamed that they are being beaten. Because of repeated emotional - as well as physical - abuse, many victims of domestic violence often have low self-esteem and believe that they don’t deserve help.

Some women may be afraid to reveal the truth because they fear retribution. Batterers frequently threaten to kill the woman or other family members if they tell anyone about the beatings. Finally, some battered women may still love their male partners despite the battering. They may then lie to protect them from arrest or public disclosure.

The presence of the perpetrator at the scene may also be a barrier to recognizing domestic violence as the cause of a woman’s injuries. The abuser may be present when EMS personnel arrive at the scene and appear concerned - even *overly* concerned - about the victim’s well-being. It is not uncommon for a batterer to speak for the victim, giving an alternative explanation for her injuries.

On the other hand, the perpetrator may be extremely hostile, and providers may avoid asking pertinent questions to avert a potentially dangerous confrontation. On occasion, the woman herself may be hostile, even threatening police or paramedics who have arrived at the request of friends or neighbors. She may behave this way to prevent the man from being arrested or because she knows that if she doesn’t act aggressively to prevent this “intrusion” into his home, she will suffer a more severe beating later.

However, there are specific signs that should raise prehospital providers’ levels of suspicion about abuse in a household (see Table 1).

EMS personnel are in the position to be “watch dogs” or environmental observers for activity that may suggest domestic violence. In fact, sometimes the EMS team may be the only witnesses to a domestic violence “environment.” This unique position can allow them to help individuals who may never reach health care facilities because of their severe isolation or the batterer’s control over their lives.

It is up to EMS providers and their powers of observation to be able to “read between the lines,” staying alert for clues such as signs of a fight, including broken furniture, an unkempt house or other people on scene (such as children or neighbors) who may be hurt or appear to be afraid.

When EMS personnel do suspect a violent - or potentially violent - situation, they should inform the ED staff of this fact. Unfortunately, as seen in the opening scenario, the ED often is not given this crucial information because EMS responders either overlook clues or deem them unimportant. Also, responding personnel may harbor misunderstandings about the nature of domestic violence or the belief that it is a family issue rather than a medical issue. This may cause some providers to avoid asking direct questions about the true cause of a woman’s injuries.

Table 1.

Indications of Potential Domestic Violence

- Patient is fearful of a household member.
- Patient is reluctant to respond when questioned.

- Patient is in an unusually isolated, unhealthy or unsafe living environment.
- Patient exhibits poor personal hygiene and/or inappropriate clothing.
- Patient and another household member give conflicting accounts of the incident.
- Patient gives a history inconsistent with the injury or illness.
- Household member is angry or indifferent toward patient and refuses to provide necessary assistance.
- Household member refuses or hesitates to permit transport to hospital.
- Household member seeks to prevent the patient from interacting privately or speaking openly.
- Household member is concerned about a minor patient problem but not with the patient's serious health issue.
- There have been previous or repeat police/EMS responses to address, indicating frequent violence in household.
- There was an unexplained delay in seeking treatment for injury.

From the Suffolk County (N.Y.) Task Force on Domestic Violence.

Finally, the provider may believe that domestic violence only occurs in certain types of families (i.e., poor or uneducated families). In reality, battered women - and the men who batter them - come from every socioeconomic level, race, religion, educational background and profession. The only thing they have in common is being beaten by someone they live with or love.

Recognizing a Battered Woman

Injuries that should raise a suspicion of domestic violence include those that follow a certain pattern to the face, chest or abdomen, as well as forearm bruises and fractures, which suggest a defensive posture. Other tip-offs include the following:

- Injuries inconsistent with the explanation given by the patient. For example, be suspicious of isolated bruises on the abdomen said to be caused by a fall down the stairs or a "blowout" fracture of the face attributed to running into a kitchen cabinet. A blowout fracture, which involves a fracture of the fragile bone under the eye, typically indicates a direct blow to the face.
- Multiple injuries in various stages of healing, such as a fresh black eye combined with bruises on the neck that are already starting to change color (see Table 2).
- A substantial delay between the onset of injury and the call for help. (The woman may have had to wait for the perpetrator to leave the house before it was safe to call 9-1-1.)
- An injury inflicted during pregnancy. It has been reported that 25 percent of all obstetrical patients are battered.¹ Battering may begin in pregnancy, increase during pregnancy, or simply continue despite pregnancy. The most common injuries during this period are blows to the face, breasts and abdomen. Miscarriage, fetal injuries, early labor and death may result.
- A woman who has attempted suicide.
- The patient has a pattern of repeat calls to 9-1-1. That "frequent flier" or "crock" with a variety of psychosomatic complaints may find that her only escape from a violent household is a trip by ambulance to the ED. Many "accident-prone" women well-known to prehospital providers may actually be the victims of battering.
- Marital or date rape or sexual assault. In up to 50 percent of battering relationships, the women are also raped by their husbands or boyfriends.¹
- Drug and alcohol use. Drugs and/or alcohol abuse may precipitate an episode of battering. On the other hand, the victim may use drugs and/or alcohol to escape the pain of a violent relationship

Table 2.

Estimating the Age of a Bruise

COLOR	AGE
Red Reddish-blue	Less than 24 hours
Dark purple Dark blue	1 to 4 days
Greenish Yellow-green	5 to 7 days
Normal tint Disappearance	1 to 3 weeks

Recommendations

Safety for the victim, her children and the EMS personnel is the top priority in these situations. If a suspected perpetrator is on the scene, avoid confrontation. Transport the victim as quickly and expeditiously as possible. It is also wise to transport her children if possible to remove them from the potentially violent environment.

Ask all victims of violence and patients who you suspect are victims of abuse a few pertinent questions. (See “EMS Domestic Violence Subjective Assessment” for sample questions.) Explain that questions of this sort are asked of all injured patients and of all patients where there is a particular concern.

Question the victim directly about battering only if the suspected abuser is not present. Accusing the perpetrator in public may lead to retaliatory beating in private. An affirmative response to these questions should provoke an immediate report to the ED, which should be prepared to offer a multidisciplinary approach to helping the abused patient. When EMS responders and ED staff members work as a team, they can help the victim significantly.

Be sure to communicate and document your observations and concerns about domestic violence directly to the emergency physician and/or emergency nurse who will be caring for the patient in the ED. Don’t leave this to the patient; she may be reluctant to communicate the truth to them for the reasons discussed previously.

Note relevant occurrences at the scene, and document them in the run sheets. These can be useful if the victim chooses to press charges either now or in the future. They can also be used if the woman chooses civil action, such as legal separation, divorce or child custody hearings.

The issue of domestic violence – and other forms of interpersonal violence – should be addressed in all EMS training programs. EMS instructors/coordinators should integrate this subject into every presentation on injury prevention, and communities should work together to make recognition of domestic violence a priority.

In Suffolk County, N.Y., for example, the Suffolk County Task Force on Domestic Violence and Division of Emergency Medical Services has worked together to develop a policy for recognizing and handling domestic violence. EMS responders in the area are now required to conduct a subjective assessment to determine the possibility of domestic violence on all victims of trauma (except where the cause of the injuries is clearly known or obvious) and in cases of illness where there is significant level of suspicion. This last is difficult to determine but may

include chronic abdominal pain or headache that results in numerous calls for help (the “frequent flier”) or signs and symptoms and time frames that seem inappropriate.

EMS Domestic Violence Subjective Assessment

The ambulance may provide a “safe” environment for the victim of domestic violence to admit to a problem and ask for assistance. This is the ideal opportunity for an EMS responder to question the patient and hopefully uncover any abuse that is occurring.

Ask the patient direct, non-threatening questions in an empathetic manner, emphasizing that these questions are asked of all trauma patients and others where there is a particular concern.

If a child is involved and provides information that gives you reasonable cause to suspect child abuse or neglect, do not ask further questions. Simply be positive and receptive if the child continues to talk.

Sample Questions to Ask Suspected Abuse Victims

- ◆ We often see people with injuries such as yours that have been caused by someone else. Could this be happening to you?
- ◆ You seem frightened. Has anyone hurt you?
- ◆ Many patients tell me they have been hurt by someone close to them. Is this what happened to you?
- ◆ Sometimes when others are overprotective and jealous, they react strongly and use physical force. Could this be happening to you?
- ◆ Are you afraid of anyone in your household?
- ◆ Has any household member physically hurt you or threatened you?

All of these questions may not be appropriate to ask all patients. The EMT or paramedic must decide which questions should be asked and how, if necessary, these questions should be modified for that particular patient. One or more questions must be asked of all victims of injury except where the cause is clearly known or obvious. In cases where there is a high level of suspicion based on documented indicators, multiple questions may be necessary.

You may find it difficult to ask these questions. However, they should be part of your patient assessment. Asking them is the first step toward appropriate care.

Training is also now mandatory in all ALS and BLS refresher courses in the Suffolk County area. Each prehospital care provider also carries a palm card that contains suggestions for recognizing and interviewing possibly battered patients.

Educate yourself about domestic violence. Given the magnitude of the epidemic of spousal abuse in our country, it is likely that not only are your patients affected by the problem, but also that someone in your family, your neighborhood or your workplace is being abused. Your sensitive questions and offer to help may be the impetus needed to turn a life around.

References

1. American Medical Association: *Diagnostic and Treatment Guidelines on Domestic Violence*. Chicago: American Medical Association, 1992.
2. Walker LE: *The Battered Woman Syndrome*. New York: Springer Publishing Co., 1984.

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HELPING THE BATTERED WOMAN HELP HERSELF

By Mike Meoli, EMT-P

Mike Meoli, EMT-P, a paramedic for 14 years, currently works as a field-training officer for American Medical Services in San Diego. He also serves as an interventionist on the San Diego Police Department Crisis Intervention Team and teaches crisis intervention.

FREQUENTLY, VICTIMS OF DOMESTIC VIOLENCE will refuse to do anything to help change their situation. Even if the perpetrator goes to jail for a night, the victim may continue to deny the need to make changes in her home life. As an EMS provider, you are an “environmental witness,” and you may be the one person to hear from the victim that a problem exists. If you find yourself in this type of situation, there are several things you can do to help. In addition to carefully documenting all the signs and symptoms of domestic violence you observe, consider referring your patient to the closest domestic violence hotline for possible future use. This is especially important if the victim is refusing transport to the hospital. However, it can also be done effectively in the back of an ambulance while you have a brief opportunity to talk with the victim in a confidential setting.

Here are some tips on how to effectively make a referral:

- Emphasize that the violence is not her fault.
- Convey your concern that the violence against her (and any children) will recur and increase if she doesn’t seek help.
- Tell her that she is not alone, that there are people who understand her situation and want to talk to her.
- Don’t push her to “leave her man” if she is clearly telling you that she is not ready to do so. Rather, refer her to the closest domestic violence hotline, where she can talk confidentially to someone who understands her dilemma. Let the phone counselors provide her with the emotional support she needs followed by the legal, financial and logistical (shelter) support she might require when she is ready to make a change.
- Write the number of an appropriate hotline on a card or piece of paper that she can place in her wallet or purse. Don’t write the words “battered” or “violence” on the card; she may be in more danger if her mate finds the card. Simply write “women’s service,” followed by the local phone number.

To find the closest battered women’s service in your area, contact the National Domestic Violence Hotline at 800/799-7233.

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WHY WOMEN STAY

A Physician Speaks of Her Own Abuse

Editor's Note: *For many people not acquainted with realities of domestic violence, there is a tendency to blame the victim, to become impatient and ask why the victim doesn't "just leave." This letter may answer some of those questions*

BY GIVING UP MY PRIVACY AND RISKING criticism by colleagues and friends, I will try to illustrate the painful and humiliating fact that domestic abuse penetrates even the "best" families and affects the strongest people. I know, I am a survivor of spouse abuse. One of the most difficult emotional decisions to understand is why, at the first sign of aggression or mistreatment, a woman does not or cannot leave a man who abuses her. It sounds straightforward and easy, but is it?

Let me begin by saying that abusive relationships do not start with violence. Women do not enter into a relationship saying, "It's OK to hurt me." Even abusive relationships usually start romantically, sharing love and trust, building dreams together, and often having children - just as in a normal relationship.

Often, the spouse's controlling behavior is not seen immediately, but develops slowly over time. When a woman realizes how damaging her relationship is, she often has already made an emotional commitment and developed a sense of loyalty to her partner. The bonds between the couple have been built over time and do not suddenly cease to exist. Once abuse enters the relationship, her emotional ties are a great source of turmoil. I know when I took my marriage vows, I meant "for better or for worse." But when "until death do us part" suddenly became a frightening reality, I was faced with some terrifying decisions.

There are myriad and complex reasons for staying in an abusive relationship. The simplest for society to grasp is the fact that many women have no other source of financial support or housing. We ask them to leave their homes behind, cloaked only by the temporary safety of darkness, to hide in community shelters (when there is room), or to live on the streets. Now add the responsibility of caring for several small children onto her shoulders. How many people would choose to take their children from their home, with no guarantee of food or shelter? How realistic are the options that we insist are the "obvious solutions" to this problem?

The fear of retaliation and further victimization by the abuser is another serious concern. The abused woman realizes that if the abuser catches her preparing to leave or finds her once she has gone, his threats to harm her or her family may soon become a reality. Once, when I tried to leave my ex-husband, he took my dachshund puppy and beat him against the wall. He told me to remember those cries, because if I ever left him or tried to get help, those cries would haunt me because they would be the cries of my young niece. At that moment I knew he was capable of every horrible threat he had ever made, and my life was in grave danger.

Abuse by an intimate partner, either emotional or physical, is a commonly unrecognized cause of illness and injury among women. Recent estimates reveal that from 2 million to 4 million women are battered by their "significant others" each year. How long can we, the medical community, continue to ignore this horrifying crime? [Health care personnel] are on the front lines of dealing with victims of these acts of violence and have the ability to affect the prevalence of this form of aggression. We also have the responsibility to show compassion.

How can you help? First, educate yourselves, as well as your colleagues and community,

about domestic violence. Try not to make value judgments. Your interaction with an abused patient has an incredible effect on her; she is searching for someone to believe her and, if possible, to offer an alternative. An attack by a loved one is an emotionally shattering experience. She needs compassion, not criticism or condescension.

Finally, realize that your actions, or lack of action, can have a huge impact on her life. Be aware that by not asking whether domestic abuse is the cause of your patient's injuries, you could be closing your eyes to the fact that this woman will most likely return home, only to be beaten again... and again.

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ELDER ABUSE: EMS on the Front Lines

by **William A. Storm**

The tones sound in your headquarters and your dispatcher speaks the words she's said and you've heard a hundred times before: An elderly woman cannot be roused from what seems to be deep sleep, and the phrase "cerebral vascular accident" enters your consciousness. Upon arrival at the patient's home you find that her son lives with her and appears responsible for her care, as she is semi-invalid. You begin your workup, taking vitals and preparing for your ALS transport, your partner preparing the IV, then collecting information from the son. Your LifePak reveals that your patient is in atrial fibrillation; the clots forming from this, you recall, can precipitate a CVA.

Your partner asks the son about medications she was on, and he pulls a tray from the kitchen cabinet with the familiar smorgasbord of amber vials. Among them is a vial of Coumadin, an anticoagulant, which your partner notices is nearly full, but with a fill-date three months prior to your call. Your partner also notices that the son is relaxed and casual, curious about your equipment, and talking about how much he admires "the things you people do."

With your unconscious patient delivered to the nearest emergency room, you take the information gathered by your partner to complete the paperwork, and you notice the odd note about the full bottle of Coumadin. You can see the son sitting in the waiting room, legs crossed, browsing through *Sports Illustrated*, head bobbing in time with the piped-in easy-listening music, a cup of coffee from the vending machine sloshing between his fingers. You close your eyes and massage your forehead with your fingers as a new phrase enters your consciousness, intruding on what was moments before the thoughts of writing up a routine CVA call: "crime scene."

EMS: The First Line of Defense

As the first professional medical contact for millions of elders in our country, EMS providers form the initial bulwark against a deep societal illness that is growing at least as fast as our population of elders. As difficult as this issue is for elders and caregivers alike to acknowledge, it is often EMS and the Emergency Department that are first to encounter the warning signs or the sad results of abuse and neglect. Compounding the mystery that is fed by the denial and shame of victims and perpetrators alike is the frustrating lack of monsters on which to pin crimes. Unlike the fictional account above, abusers of elders are often caregivers who are themselves emotionally spent, financially strapped, and understandably angry in their role, and whose sense of guilt only delays the necessary and available interventions. The fact that the last two generations of Americans have seen the average family size drop significantly is good news for the environment and dwindling resources, but it is bad news for elders whose care at the end of their lives rests on the shoulders of fewer

offspring, who are themselves usually women, and who increasingly are single heads of households with children. In the realm of elder mistreatment, it will be medicine and law enforcement which reap the ironic harvest sown by the reproductively responsible baby-boomers.

A Recent Awareness

While most medical caregivers have long been sensitized to the need for vigilance against child abuse, it has only been since the 1970s that abuse of our elder citizens has entered the public's awareness, and not until 1981 was the attention of government regulators turned to the issue of elder abuse.

While elder abuse has traditionally thrived under the veil of family secrecy, this condition which is estimated to afflict 1.84 million individuals, or roughly one in twenty,⁽³⁾ is now well within the purview of medical intervention, with most states requiring professionals to report suspected abuse directed against elders as well as children. Also, while the overt abuser is the headline-grabber, a majority of elder abuse cases resulted from neglect of the elder, though with equally disastrous outcomes. Three-fifths of the victims are female, the average age of a victim being 77-years-old.⁽¹⁾

The Role of EMS

Because medical caregivers are among the group designated as "mandatory reporters of elder abuse," failure to report suspected abuse exposes medical professionals to malpractice and negligence lawsuits.⁽²⁾ It is reasonable to expect all emergency personnel to be familiar with common warning signs that would generate such suspicion, as elders will not commonly report abuse or neglect of which they are the victims. Self-neglecting elders comprise roughly one half of that total, the other half being the victim of an abuser. Possibly the most disturbing data is the estimate that only one in fourteen incidents of domestic elder abuse ever come to the attention of the authorities, with 241,000 reports of abuse in 1994.⁽¹⁾

Not unlike cases of child abuse which find their way to the attention of social service providers via medical personnel, 22 percent of all cases of elder abuse come to light via physicians and other medical providers. This level of reporting makes them the single largest reporting group, with family members reporting 15 percent of cases, and other service providers less than 10 percent. In the medical profession, rarely does an individual provider see enough evidence of abuse to form more than a suspicion. Moreover, the provider may feel loathe to report his or her often insubstantial suspicion based on a gut feeling or suspicious answer in an interview. It should be reassuring to know that 60 percent of reports of suspected abuse are substantiated following further investigation, with roughly half of the reports being cases of self-abuse.⁽¹⁾

As there will be more than 72 million Americans over age 60 by the year 2000, the encounter with abused elders by EMS personnel can only increase, thus putting abuse near the top of an already crowded list of conditions to be ruled out by EMS and ED

personnel. In addition to the sheer numbers of elders, the ratio of available care givers to elders will fall to even lower levels with the aging of the baby boomers in the next twenty years, and abuse of the elderly will seem as familiar as an MVA or "difficulty breathing."

Factors to be Considered in Patient Evaluation:

- Data indicate that elder mistreatment occurs among men and women of all racial, ethnic and socioeconomic groups, with no group over or underrepresented.
- The abuser is most often the adult child of the victim, but can also be the spouse or paid or casual caregivers.
- Physical, functional or cognitive problems in caregivers may prevent them from providing proper care.
- Mental illness, alcoholism, or drug abuse in the older person or caregiver may be associated with the problem.
- Social isolation and dependence of the elderly person may increase the risk for mistreatment.
- A past history of abusive relationships may predispose the victim to future mistreatment.
- Financial or other family problems may impair the ability to provide adequate care.
- Inadequate housing or unsafe conditions in the home may increase the likelihood of mistreatment.
- Victims often have experienced several forms of abuse at the same time.⁽²⁾

Patient Interviews

Physicians dealing routinely with the elderly are advised to incorporate questions related to neglect and abuse in their interviews, so it would seem prudent that EMS personnel have available in their arsenal of assessment tools questions which could more fully illuminate a picture of the condition of their patient. While abuse can certainly be a source of great shame to your patient, direct questions such as the following suggested by the AMA can help you develop the needed information. If your patient has significant dementia, attempt to find someone who can respond to your questions and who would not be a likely perpetrator. Questions directed to your patient should always be done away from the caregiver or suspected abuser.⁽²⁾

- Has anyone at home ever hurt you?
- Has anyone ever touched you without your consent?

- Has anyone ever made you do things you didn't want to do?
- Has anyone taken anything that was yours without asking?
- Has anyone ever scolded you or threatened you?
- Have you ever signed any documents that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you take care of yourself when you needed help?⁽²⁾

It is important to remember that you are not in the position of proving that mistreatment occurred, nor do you need to elicit positive responses to the above questions to develop a justified suspicion that mistreatment is occurring. Professionals are required only to have "reasonable cause" to suspect that abuse has occurred. The AMA states that "reasonable cause reporting can be as simple as stating that the patient seems to have health or personal problems and needs assistance, especially if the clinician suspects forms of abuse or neglect that are difficult to quantify."⁽²⁾ Whether merely reporting any suspicions of abuse to the ED is sufficient in the case of a transported patient or whether the EMS agency should make its own separate report to authorities will likely vary by jurisdiction. Establish protocols to assure that your suspicions are documented and relayed promptly and without fail to the appropriate authority.

Forms of Abuse

PHYSICAL NEGLECT is by far the most common form of elder mistreatment, representing 58.5% of reported cases of abuse in 1994.⁽¹⁾ Examples include withholding of health maintenance care, including food and water, physical therapy or hygiene; failure to provide physical aids such as eyeglasses, hearing aids, or false teeth; and failure to ensure a safe living environment.⁽²⁾

PHYSICAL ABUSE accounted for 15.7% of cases in the same year.⁽¹⁾ Examples include pushing, striking, slapping or pinching; force-feeding; incorrect positioning; improper use of physical restraints or medications; and sexual coercion or assault (sexual contact or exposure without the older person's consent or when the older person is incapable of giving consent).⁽²⁾

PSYCHOLOGICAL ABUSE includes verbal berating, harassment or intimidation, threats of punishment or deprivation, treating the older person like an infant, and isolating the older person from family, friends or activities.⁽²⁾

PSYCHOLOGICAL NEGLECT is the failure to provide the elder with social stimulation, including leaving the older person alone for long periods of time; ignoring the older person or giving him or her the "silent treatment", failing to

provide companionship, changes in routine, news, or information.⁽²⁾

FINANCIAL OR MATERIAL ABUSE OR NEGLECT, while not within the common evaluation protocols of EMS, may become evident in your observation of the scene or in the course of conversation with your patient and as such must be reported to authorities. Examples of these include denying the older person a home, stealing money or possessions, coercion into signing contracts or powers of attorney, and coercive changes in wills or the purchase of goods. Financial abuse or neglect should certainly be suspected if the patient appears to be suffering from substandard care in the home despite obvious resources for providing that care evident in the residence. On-scene EMS is in a unique position to make this particular evaluation for the medical team encountering this patient.⁽²⁾

Institutional Neglect and Abuse

All of the above conditions can be found to occur in nursing homes and other residential facilities for the elderly. Abusers can include staff members, family, visitors, other patients, and even intruders. A form of mistreatment unique to these settings is the failure to carry out treatment plans involving misuse of prescribed medications, or unauthorized use of physical or chemical restraints. The chronic shortage of qualified staff for these institutions results in inadequate care for these patients, many of whom are in severe states of dementia, are chronically ill and frail, and who have few visitors to monitor their care. An EMS responder to one of these facilities should be aware of the great potential for abuse and neglect presented by such an institutional setting where ill treatment can become the norm in the absence of close monitoring by authorities.

Agencies for Reporting Abuse

Each state has a system in place to handle elder abuse and neglect. Check with your local protocols and social service agencies to determine the most appropriate avenue for referrals. Below is a list of possible resources for referral and action:

- **State Elder Abuse Hotlines:** Many states have instituted 24-hour toll-free numbers for receiving reports of abuse. Such calls, as are all reports of suspected child or elder abuse, are confidential.
- **Medicaid Fraud Control Units (MFCU):** Every State Attorney General's Office is required to have a MFCU to investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care programs which participate in Medicaid, including home health care services.
- **Law Enforcement:** Local police, sheriff's offices, and prosecutors may investigate and prosecute abuse, particularly in cases involving sexual abuse or assault. In states whose statutes make elder abuse a crime, there may be a requirement to report suspected abuse to a law enforcement agency.
- **Long Term Care Ombudsman Program:** Since passage of the 1975 Older

American's Act, every state has had a long term care ombudsman program to investigate and resolve nursing home complaints. Check with your State Unit or Area Agency on Aging to see if the long-term care ombudsman program in your area can help in any given instance.

- Information and Referral: Every Area Agency on Aging operates an information and referral line that can refer people to a wide range of services that can locate help in preventing abuse and neglect.
- National and State Information: To provide care for friends and relatives who don't live near you, the national Eldercare Locator number is (800) 677-1116 to find services in the older person's community. Some states have also established toll-free numbers to provide this information within their state. ⁽¹⁾

References:

1. "Understanding the Nature and Extent of Elder Abuse in Domestic Settings," Summary of Findings from the National Center on Elder Abuse, 1994. For more information, contact the NCEA at 810 First Street, N.W., Suite 500, Washington, DC 20002; (202) 682-2470 or (202) 682-0100.
2. "Diagnostic and Treatment Guidelines on Elder Abuse and Neglect;" American Medical Association, 1992.
3. "A Call for Help!: The Untold Story of Elder Abuse," by Susan Littwin, New Choices Magazine, September, 1995.

CURRICULUM TIME LINE

START TIME	TOPIC
0:00 - 0:10	Introduction and Definition of Domestic Violence (10 minutes)
0:10 - 0:20	Scope of the Problem (10 minutes)
0:20 - 1:05	Domestic Violence: A Pattern of Behaviors (45 minutes)
1:05 - 1:15	Domestic Violence: Purposeful, Coercive Behavior (10 minutes)
1:15 - 1:35	Understanding the Causes of Domestic Violence (20 minutes)
1:35 - 1:45	Phases of Violence (10 minutes)
1:45 - 2:00	Role of EMS Providers (15 minutes)
2:00 - 2:20	Responding to a Domestic Violence Scene (20 minutes)
2:20 - 2:40	Recognizing and Treating Victims of Domestic Violence (20 minutes)
2:40 - 2:50	Assessing Injuries (10 minutes)
2:50 - 3:00	Documentation (10 minutes)
3:00 - 3:15	The Aftermath (15 minutes)
3:15 - 3:30	How Domestic Violence Affects Children (15 minutes)
3:30 - 3:50	Legal Aspects of Domestic Violence (20 minutes)
3:50 - 4:00	Prevention Strategies and Summary (10 minutes)